# Bima Health Limited

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bima Health Limited

**Premises audited:** Sunhaven Rest Home & Private Hospital

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

**Dates of audit:** Start date: 21 July 2016 End date: 22 July 2016

**Proposed changes to current services (if any):** Currently building on to the existing premises. When completed, the two services will be separated. The timeframe for completion is the end of November 2016. It is proposed that overall this will provide 20 dementia level care and 20 psychogeriatric beds with supporting facilities for each unit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 33

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Sunhaven Rest Home and Private Hospital provides rest home dementia care and psychogeriatric hospital level care for up to 37 residents. The facility is operated by Bima Health Limited

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service’s contract with the district health board (DHB). The audit process included the review of policies and procedures, supporting documentation, review of resident and staff files, observations and interviews with residents, families, management, staff and a GP.

The areas that required improvement from the previous audit relating to the activities programme and enabler use have been addressed.

There are 10 areas requiring improvement from this audit relating to corrective action plan implementation, referral of residents to the Needs Assessment and Service Coordination (NASC) team for reassessment, evaluation of care plans, short term care plans in response to changes in a resident’s condition, the management of medicines, restraint documentation including an appropriate policy, a restraint register, assessment and evaluation and surveillance of infections.

## Consumer rights

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

Systems are in place to facilitate open, effective communication with family members. This includes detailed entries on the resident progress notes each shift, and family members being encouraged to participate in the care planning process, including the six-monthly multidisciplinary resident review.

Information regarding residents’ rights, access to interpreter services and how to lodge a complaint was available to residents and their families. The complaints register is current and all complaints have been entered. Residents and their families reported their satisfaction with the open communication with staff.

There have been no investigations completed by the Health and Disability Commissioner and other external agencies since the previous audit.

## 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. |

Bima Health Limited is the governing body and is responsible for the services provided. A business management plan and a quality and risk management plan were reviewed. An organisational flow chart details the positions of staff in the organisation.

The facility is managed by a facility manager who has been in this position for nine years. The facility manager is supported by three clinical coordinators/registered nurses and who are responsible for the oversight of the clinical services in the facility.

There is daily communication between the facility manager and the owner. The clinical coordinators meet with the facility manager daily.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collected, collated and analysed. Graphs of clinical indicators are available for staff to view along with meeting minutes.

Documentation, including policies and procedures have been reviewed and are current. There are policies and procedures on human resources management. In-service education is provided for staff at least monthly. Care staff reported they have either started or completed the New Zealand Qualifications Authority Unit Standards, including the dementia modules.

A documented rationale for determining staffing levels and skill mixes is in place to provide safe service delivery. The facility manager and clinical coordinators are rostered on call after hours. Care staff reported there is adequate staff available.

## 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. |

Residents have detailed care plans, which are developed and evaluated within required time frames. Residents are seen promptly by the doctor on admission, reviewed regularly, and referred promptly if their clinical needs change.

Three registered nurses share the clinical coordinator position, and if they are not on site one of these staff is always available on call, together with the facility manager. Registered nurses are on duty 24 hours a day and provide support and guidance to the caregiving staff. Verbal handovers at the start of each shift, a written report for registered nurses, and updating of residents’ progress notes each shift help promote continuity of residents’ service delivery. Registered nurses, all of whom have completed medication competency assessments, are responsible for medication administration.

All aspects of food service delivery and management comply with legislation and guidelines. Kitchen staff have completed food safety training, and the kitchen was clean and tidy. A range of individual resident food likes/dislikes, as well as dietary and cultural needs, are accommodated, and there are well-established systems in place to monitor resident food/fluid intake on a daily basis. The summer and winter menus operate on a four-weekly menu cycle, and have been recently reviewed by a registered dietitian.

An experienced diversional therapist coordinates the activities programme, which provides a range of activities seven days per week. A previous finding related to ensuring the activities programme was meaningful to residents has been addressed.

## Safe and appropriate environment

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

A current building warrant of fitness is displayed. An extension to the existing building is currently being built and will provide accommodation and supporting facilities for 20 dementia level care residents.

## Restraint minimisation and safe practice

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

Documentation of policies and procedures and interview of the facility manager demonstrated residents are experiencing services that are the least restrictive. There are currently residents using restraint. There are no residents using an enabler.

## Infection prevention and control

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

Well-developed processes and systems are in place for collecting and collating infection-related data. Surveillance results are reported to the clinical quality committee, and discussed at staff meetings.

## 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 | 11 | 0 | 5 | 4 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 4 | 6 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The complaints register is current and all complaints have been entered. All complaints have been investigated and complainants provided with responses in a timely manner. There was evidence that complainants were satisfied with the outcome of these complaints.  There have been no investigations by the Health and Disability Commissioner, the Ministry of Health, DHB, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.  Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Systems are in place that ensures residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Review of the collated family surveys evidenced families knew the process for making a complaint and found management very approachable.  The complaint process and forms were observed to be readily accessible and displayed. Quality and staff meeting minutes evidenced reporting of any complaints is an agenda item. Care staff confirmed information was reported to them via their staff meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | All resident records reviewed included evidence of open disclosure and timely communication with residents/families. Communication was documented in family communication sheets, on accident/incident forms as well as the detailed documentation in the residents’ progress notes. Four family members interviewed stated they were informed in a timely manner about any changes to the resident’s status, and appreciated the ongoing communication with staff. A fifth family member did not feel confident they were being kept fully informed. Evidence was sighted of both families, and where possible, residents having input into the care planning process, and of family input into the six-monthly multidisciplinary residents’ reviews.  A clinical coordinator advised that interpreter services were able to be accessed from the Taranaki District Health Board when required. In addition, facility staff also speak a number of languages and are available to assist, as required. |
| 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 business management plan includes a philosophy, objectives, a mission statement, values and a vision. There are systems in place for monitoring the service and regular daily communication takes place between senior management and the owner. The owner shares an office with the facility manager and works in the business.  Sunhaven Rest Home and Private Hospital (Sunhaven) is managed by a facility manager (FM) who has been in this role for nine years. The facility manager has attended management courses since the last audit and attends the DHB leadership forums every three months. The facility manager is supported by three clinical coordinators and the owner. The facility manager also stated they are supported well from personnel from their local DHB. Two of the clinical coordinators are experienced registered nurses and the third is currently being orientated to their role. The annual practising certificates for the clinical coordinators are current. There was evidence in the clinical coordinator’s files of education, including that relating to clinical governance.  The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  Sunhaven is certified to provide psychogeriatric hospital and rest home dementia care. On the first day of this audit there were 20 psychogeriatric level care residents and 13 rest home dementia level care residents. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | A risk assessment and management plan is used to guide the quality programme and includes goals and objectives.  Quality improvement data is being collected, collated and analysed and trends identified. There was good evidence of this for clinical indicators, including corrective actions and graphing, and this information is being reported back to staff. Staff confirmed this. Although there was evidence of corrective actions being developed following deficits identified in internal audits, there was no evidence of implementation, who was responsible and timeframe for completion. Where there were deficits identified, for example the medication audit, there was no evidence of improvement. There was some evidence in the meeting minutes of corrective actions brought forward from internal audits, however, evidence of implementation was inconsistent.  Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures have been reviewed and are current. The restraint policy is not appropriate to the services provided (refer criterion 2.2.1.1).  A health and safety manual is in place. There is a hazard reporting system available. A hazard register identified potential health and safety risks and includes risks associated with human resources management, legislative compliance, contractual and clinical risks. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews of staff evidenced appropriate management of adverse events.  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. The family survey also confirmed this.  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 facility manager and owner reported there have not been any essential notifications to the Ministry of Health since the last audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority. Staff files sampled had evidence of reference checking, job descriptions, employment agreements, an orientation, police vetting and current performance appraisals.  The facility manager is responsible for the in-service education programme. The in-service education programme for 2015 and 2016 evidenced education is provided at least monthly for staff and covers all required topics. Outside speakers present some sessions and staff also attend educations externally. All staff have either completed or started the dementia specific modules through New Zealand Qualifications Authority Unit Standards. Registered nurses are responsible for medicine management. Staff files evidenced current competency assessments, however, education around medicines has not been provided in the last two years. (Refer criterion 1.3.12.1). Restraint competency assessment are current for all clinical staff. Two of the RNs are trained in the interRAI assessment programme and have documentation that verifies they are currently competent.  There are policies and procedures on human resources management. Annual practising certificates are current for registered nurses and contracted health professionals who require them. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week. On call after hours is provided by the facility manager and coordinators. The minimum number of staff on duty is during the night and consists of a registered nurse (RN) and three caregivers.  Staff interviewed reported there is adequate staff available and that they are able to get through their work. Family interviewed reported staff provide their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Registered nurses, all of whom had been assessed as competent in medication administration, are responsible for medication administration in the facility. A clinical coordinator and the doctor advised that there had been some recent difficulties with the contracted pharmacy in relation to the faxing of prescriptions and subsequent supply of medications, with systems now being put in place to address this. The facility manager and service owner confirmed that the service will be moving to an electronic medication management system later this year. Service improvements are required in relation to the maintenance of the controlled drugs register, medication administration records, medication prescriptions, and medication-related education for registered nurses.  An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. No residents are self-medicating. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | An experienced and qualified cook, including food safety qualifications, is responsible for food services. The kitchen caters for a range of nutritional requirements, including diabetic, soft and puree diets. A four weekly menu, with summer and winter options, was last reviewed by a registered dietician in May 2016, report sighted. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly and nutritional supplements administered as prescribed. Refer also to criterion 1.3.8.2. Two dining areas are available for residents.  On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. 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. Experienced and appropriately qualified staff are responsible for food services within the facility. Resident satisfaction with food is monitored through informal conversations with residents, and careful monitoring of what residents are eating, as well as monthly weighing. There are well-established systems in place to ensure that all residents are offered food and fluids on a regular basis. Residents talked with during the audit visit confirmed that they enjoyed the meals and they were provided with ample quantities of food. Their comments were also echoed by family members. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | There was evidence in residents’ records reviewed of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Refer also to criteria 1.3.3.3, 1.3.8.2, 1.3.8.3. InterRAI assessments were current and there are effective processes in place to ensure assessment outcomes are reflected in residents’ care plans. Residents’ progress notes are updated each shift. Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff. The doctor visits weekly and expressed confidence that their prescribed care was being implemented, and that they were being advised in a timely manner when residents’ needs changed. The doctor noted that registered nursing staff had been “stretched” recently when there was a sudden influx of a number of new residents. During the audit visit, staff were noted to respond promptly, professionally and patiently to residents requiring additional or urgent support and guidance.  Three residents have recently been assessed as no longer requiring the specialist care provided by the service, and transfer to other facilities is currently in process. The documentation in their clinical records indicated that in the interim their care needs are being met, except in relation to wound care management. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are two members of the diversional therapy team – the qualified diversional therapist, with three years’ experience in this role, and a caregiver who has been working in the activities programme for eight months. Between them they provide 42 hours of formal activities weekly, with other activities offered on a more informal basis by care givers.  The diversional therapist and their assistant advised that residents’ previous and current interests are assessed on admission and individual activity plans completed within three weeks and reviewed six monthly, as confirmed in resident records. These plans help inform the development of the activity programme, which is provided to both groups and on a one-on-one basis. A weekly activities programme is developed, but as the diversional therapy team explained, there is flexibility around programme delivery, so that they can accommodate and respond to resident wishes and preferences on the day. The activities programme includes crafts, games, entertainment, music therapy, puzzles and quizzes, a variety of outings using mobility taxis, walks, aromatherapy, sensory stimulation activities and music therapy. An individual record is maintained of resident participation in the activities programme, summarised every two weeks, and reviewed six monthly, as confirmed in resident records. Three residents, and two family member advised that the activities programme was meeting resident needs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Resident’s long-term care plans are consistently evaluated by registered nurses at least six-monthly, although the detail included in those evaluations was often limited. Wound care evaluation was infrequently documented, and the evaluation of strategies to prevent constipation was also erratic when residents were independent with toileting.  Although residents have comprehensive care plans, these plans were not always updated to reflect changes in care needs or new plans developed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed. A new unit is currently being built that will extend the existing building. This will, when completed, provide separate units for residents assessed as requiring rest home dementia level care and residents who require psychogeriatric hospital level care. The owner advised once finished the two units with supporting facilities will accommodate 20 dementia level care residents in the new unit and 20 psychogeriatric hospital level care residents in the existing building. The owner advised the building work is scheduled to be completed by the end of November 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | The service has a structured approach to monitoring infections. Surveillance data is collated and analysed by the infection control coordinator, and reported through a variety of mechanisms to staff and management. Data is not currently being analysed in relation to recent trends. Each month a corrective action form is completed related to the surveillance results, including non-conformance details, remedial action and root cause analysis. Refer also to criterion 1.2.3.8.. Surveillance results are discussed at the clinical quality meeting and reported at staff meetings, as evidenced in meeting minutes. The infection control coordinator advised that results are also informally discussed at staff handovers should any issues/concerns be identified, which was confirmed by several staff. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There were no residents using enablers and three residents using restraint. There was evidence that staff are activity minimising the use of restraint. Restraint use has decreased by two since the last audit and the restraint coordinator stated it is their aim to have no restraint used at all. Staff were able to describe the process should restraint be required and were clear about the difference between a restraint and an enabler. Management and staff interviewed now have a clear understanding of the definition of an enabler. Mobility aids documented as an enabler at the last audit are no longer classed as enablers. |
| 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. | PA Low | The restraint policy and procedure is not appropriate for the size and complexity of the organisation. The policy is more aligned to a big organisation and there is reference to a DHB. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low | Residents are assessed before restraint is used. However, the assessment form does not include items (a) to (h) under 2.2.2.1. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | Individual forms were being used as a register for each resident. There is no overall restraint register that documents all residents using restraint, the date restraint commenced, type of restraint and when any restraint was discontinued. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | There is evidence of evaluation of individual restraint use completed on a regular basis, however, there is no evaluation form to meet the requirements set out under standard 2.2.4.1. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | There was good evidence of corrective actions for clinical indicators, with graphing of data. This information is being reported back to staff as confirmed by staff. There was evidence of corrective actions being developed following deficits identified in internal audits, however, there was no evidence of implementation, who was responsible and timeframe for completion. For example, the medicine audits for the last two years had a number of deficits, but there was no evidence of improvement. The medicines audit completed in September 2015 had corrective actions developed. There was no evidence of implementation and review for effectiveness, with the next medicines audit scheduled for 12 months’ time. There was some evidence in the meeting minutes of corrective actions brought forward from internal audits, however, documented evidence to support implementation was inconsistent. | There was no documented evidence of corrective actions developed for deficits identified in internal audits. Meeting minutes evidences some implementation of corrective actions, however this was inconsistent. | Corrective action plans are implemented for all areas requiring improvement.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medication, using the robotics medication system, is supplied to the pharmacy on a monthly basis, with evidence sighted of registered nurses checking this medication on arrival in the facility. Surplus and expired medication is taken to the pharmacy on a regular basis by the facility owner. All medications sighted in both the medication trolley and in the medication cupboards were within current use-by dates. The currency of medication is checked fortnight by registered nurses, and these checks were documented.  All of the sixteen medication charts reviewed contained a current photograph of the resident, their allergy status was documented, three-monthly medication reviews were documented, and with one exception medication administration records were complete. In that instance, a medication was charted to be administered fortnightly. The administration record for that medication did not include the resident’s name or NHI number, and there was no documented explanation as to why one dose of the medication had not been administered, although a clinical coordinator advised that the resident had refused the medication on that occasion. Three medication charts included medications that had been discontinued (dated and ruled through) but did not include the signature of the prescriber. In two instances new medications had been added to the medication chart, signed for by the prescriber but the date of the prescription was not recorded.  The temperature of the medication fridge is checked weekly - records sighted, and temperatures remained within appropriate levels. Laboratory specimens were stored in the medication fridge prior to being taken to the laboratory.  The service currently has no controlled drugs in the controlled drugs cabinet. A review of the controlled drugs register confirmed that when these drugs were being used, weekly checks of medication balances were undertaken. In six instances, when these medications were no longer required they were documented as being returned to the pharmacy. However rather than the balance in the register being recorded as nil, the number that had been returned was incorrectly entered in the ‘balance’ column. In another entry dated May 2015, the balance of a controlled drug was recorded as 70mls, the remainder of the page was left blank, and there was no record of the medication having been returned to the pharmacy. A further examination of the register revealed the medication balance had been transferred to another page, and after several further doses had been administered, the remainder had been returned to the pharmacy. | 1. Aspects of medication management are not consistent with legislation, protocols and guidelines.  2. The controlled drugs register is not well maintained.  3. There was no name or NHI number on the administration record of a resident receiving a fortnightly medication, and no record of why this medication was not administered on one occasion.  4. Three discontinued medications did not include the signature of the prescriber, and in two instances there was no date recorded on the medication chart when a new medication was added to that chart.  5. RNs have current medication competency but there was no evidence of medication-related education in almost two years. | All aspects of medication management are consistent with relevant legislation, protocols and guidelines.  Nurses involved in medication administration receive medication-related education annually.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | All residents have a current interRAI assessment, as confirmed in the interRAI status report. One of the three nurses who share the clinical coordinator role explained how these assessments then inform the residents’ care plans. Two staff are currently qualified as interRAI assessors, with the facility manager advising that an additional three staff members will be booked for assessor training in the near future. The service will also make arrangements to ensure that in the interim all registered nurses are able to freely access the interRAI assessment records. In all of the clinical files reviewed, initial assessments/care plans, the development of long-term care plans, ongoing evaluations and interRAI reassessments, as well as medical admissions, regular and acute reviews had been completed within required timeframes.  A clinical coordinator confirmed that twelve residents had recently been reassessed by the Needs Assessment Service (NASC) on the basis of their interRAI assessments. These residents had not been referred to the NASC by the service when their needs levels had changed. Following reassessment by the NASC, five residents were subsequently transferred out of the facility, with plans underway to transfer out several other residents. The coordinator advised that the service had referred two residents to the NASC service when they had identified changes of care needs but there was no documentation sighted related to this.  The wound management folder included a wound register, and completed wound assessments for a number of wounds. There was no wound management documentation, including entry on the wound register, and wound evaluation/assessments, for two residents with current wounds. | 1. Residents are not being referred to the NASC service for reassessment when their level of care needs changes.  2. Wound care management plans are not in place for all residents requiring wound care. | Residents are referred promptly to the NASC service for reassessment when their care need levels change.  Wound care management plans are in place for all residents requiring wound care.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Eight resident care plans were reviewed, and all had been reviewed at least six-monthly. Approximately half of these evaluations are detailed, and contain a range of information related to how the resident has responded to the planned care. In the remainder of plans, the evaluation comments were limited to phrases such as “no changes made” rather than indicating resident progress.  The evaluation of wound management plans was not well documented. Refer also to criterion 1.3.3. Four wound management plans were reviewed. Although these all contained a completed wound assessment and management plan, only one contained a detailed wound evaluation record. A clinical coordinator advised that evaluations are most often documented in the progress notes, or in the registered nurse handover form, and some wound-related evaluations were noted in the handover forms. Refer also to 1.3.8.3. The evaluations of two residents who had experienced clinically significant weight loss in the past year did not include references to the weight loss. Both these residents had been prescribed and were being administered nutritional supplements.  The monitoring/evaluation of whether residents were experiencing constipation was consistently recorded in the activities of daily living form and a bowel-monitoring form in the clinical files of four residents who were not independently toileting. The clinical records of two residents who were independent with toileting, but had been assessed as at risk of constipation, contained little information relating to bowel status. Both of these residents had periods of up to eight days in a row without an entry in their clinical record related to their bowel status. Refer also to criterion 1.3.3. | Documented evaluations of residents’ responses to planned care do not consistently include sufficient detail and/or reflect changes in clinical status or clinical needs.  Evaluation of wound management is incomplete. | All aspects of residents’ responses to planned care are fully documented  90 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Evidence was sighted in all of the care plans reviewed that these plans were generally updated in relation to the evaluation findings, even when the evaluation details were not comprehensive. Two exceptions were the updating of plans to reflect resident weight loss, although in both instances there was evidence in the progress notes and medication charts of appropriate interventions being implemented to address identified issues.  The care plan of a resident with acute care needs, who was receiving intensive treatment related to their clinical situation, had not been updated to reflect the changes in their treatment, or a short term care plan developed related to this. | Nursing care plans are not updated and/or short term care plans developed in response to resident changes. | Nursing care plans are updated, and/or short term plans developed when resident progress is different from what was expected, and/or care needs changed.  90 days |
| Criterion 3.5.7  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. | PA Moderate | The gathering and collation of infection-related data is systematic, and records confirm this information is collected monthly. This includes infections related to skin/wound, urinary tract infections, respiratory, eye, ear, nose, mouth and gastro-intestinal. Data for each month is analysed, and a graph of that month’s results developed. At the end of each year a graph is produced that identifies infection trends and results across that year. There is currently no mechanism for ensuring that results are analysed from month to month, to facilitate the early identification of trends. | There is no evidence of surveillance data being analysed in relation to results for the previous month(s), except for the annual comparison which is completed at the end of each year. | The analysis of surveillance data includes analysis of the results, not only in relation to the monthly result, but also in relation to recent trends.  90 days |
| Criterion 2.2.1.1  The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. | PA Low | A restraint policy and procedure is in place, however, it has not been individualised to this facility. The policy is more aligned to a big organisation and references a DHB. | The restraint policy and procedure is more suitable for restraint use in a large organisation, and references a DHB. | Develop and implement a restraint policy and procedure that is appropriate to the level of service provided.  180 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Low | An assessment form is used for the assessment of residents. However it does not meet the requirements of the standard. | The assessment form does not include items (a) to (h) under this criterion. | Expand the assessment form to include (a) to (h).  180 days |
| Criterion 2.2.3.5  A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | There was no evidence of an overall restraint register and the restraint coordinator stated they have not seen one and that one would need to be developed. | A restraint register was not evidenced. | Develop and implement a restraint register.  180 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (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. | PA Low | Although there was evidence of regular evaluation of individual restraint use, there is no evaluation form that includes items (a) to (k). | There is no restraint evaluation form available that meets the requirements of this criterion. | Develop and implement an evaluation form that meets requirements.  180 days |

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

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

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

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

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End of the report.