# Heritage Lifecare Limited – Hodgson House

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Hodgson House

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

**Dates of audit:** Start date: 25 August 2016 End date: 26 August 2016

**Proposed changes to current services (if any):** Heritage Lifecare Limited (HLL) are in negotiations on the purchase of this facility and hope to go unconditional on the 8 September 2016 the change of ownership would occur around the end of the year

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

# Executive summary of the audit

## Introduction

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

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

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

## General overview of the audit

## Hodgson House provider rest home and hospital level care for up to 58 residents. The service is operate by Anglican Care Waiapu Limited and managed by a facility manger and clinical services manager. Residents and families spoke positively about the care provided.

## This provisional audit was conducted against the Health and Disability Services Standards and the service’s contract with the Bay of Plenty district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, a general practitioner and a representative of the prospective provider.

## Four areas requiring improvements identified at this audit relate to staff appraisal, service delivery plans, medication management and the kitchen environment.

## Consumer rights

## The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

## Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

## Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

## Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

## The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

## The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

## Organisational management

## Anglican Care Waiapu is the governing body and is responsible for the service provided at this facility. Anglican Care Waiapu have a strategic plan which includes the vision, purpose, mission statement, core values and passion of the organisation; this is used to developed a facility specific business plan.

## The suitably qualified facility manager is supported by a clinical manager who is a registered nurse.

## There is an organisation wide quality and risk management plan and systems are in place for monitoring the services provided, including regular monthly reporting by the facility manager through to the governing body. This includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed.

## Adverse events are documented on incident forms. Corrective action plans are being developed and implemented where required. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks and hazards are identified, mitigated and are up to date.

## A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

## The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. An annual training plan and a record of ongoing training is in place.

## Staffing levels and skill mix meet contractual requirements and the needs of residents. Senior staff are on call after hours and at weekends.

## Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained.

The quality and compliance manager for HLL provided evidence of a transitional plans which does not include change the present management structure. Heritage Lifecare Limited will review the present quality and risk process, policies and procedures and may merge some in the future.

## Continuum of Service Delivery

## The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

## Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff (eg, podiatrist, physiotherapist, pharmacist) and the residents’ general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

## Care plans are individualised, based on a comprehensive and integrated range of clinical information. Health variation plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

## The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

## Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

## The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. Residents verified satisfaction with meals.

**Safe and appropriate environment**

## The facility has been purpose built with some additions over time. Rooms consist of single, some are, ensuite, or communal, all of adequate size to provide personal care related to the services being provided in that area.

## All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative maintenance plan is in place and reactive maintenance occurs.

## Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

## Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

## Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. An emergency power source is onsite. Residents report a timely staff response to call bells. A contracted security company monitors the facility each night.

## Restraint minimisation and safe practice

## The organisation has implemented policies and procedures that support the minimisation of restraint. Fourteen restraints are in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is treated as restraint and used voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and ongoing, including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint processes.

**Infection prevention and control**

## The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is able to be accessed from an external advisor. The programme is reviewed annually.

## Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

## Aged care specific infection surveillance is undertaken, analysed and trended and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 46 | 0 | 1 | 3 | 0 | 0 |
| **Criteria** |  | 97 |  | 1 | 3 | 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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Hodgson House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, disclosure of health information and advance directives.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff are aware of how to access the Advocacy Service. |
| 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 | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The Anglican Care Waiapu has an organisation wide complaints policy with associated forms that meet the requirements of Right 10 of the Code. The facility manager stated information is provided to residents on admission and there is complaints information available at reception and the nurses’ station. This was confirmed by staff during interview. Complaints are discussed at residents’ meetings where appropriate. This was confirmed by the minutes of residents’ meetings and at interview with family members.  The complaints register reviewed showed that fourteen complaints have been received over the past year, with two this year. It includes documentation of actions taken, through to an agreed resolution; these were sighted as being completed within the timeframes specified in the Code in two complaints reviewed in depth. The register showed the required follow up and improvements have been made where possible.  The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed they have received related training and demonstrated a sound understanding of the complaint process and what actions are required. Training was confirmed on review of staff training records. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided, discussion with staff and the facility manager. The Code is displayed in a range of areas around the facility together with information on advocacy services, how to make a complaint and feedback forms.  The prospective provider knows and understands the consumer rights that it must adhere to. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, and exchanging verbal information. All residents have a private room. A “care in progress” sign is placed on the door, alerting others when cares are being attended to and not to enter at this time.  Residents are encouraged to maintain their independence and each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff interviews and training records |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | Staff support the one resident in the service who identifies as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The Māori resident interviewed reported that staff acknowledge and respected individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through, evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, physiotherapist, wound care specialist, speech language therapist, community dieticians, services for older people, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  A comprehensive training programme is in place at Hodgson House. Staff reported they receive management support for external education and accessing their own professional networks, such as attending the infection control conference and attending DHB training, to support good practice.  A physiotherapist is employed and on site four days per week, enabling resident’s assistance to maximise opportunity and independence and analysing any falls that occur. The physiotherapist also advises staff on manual handling and any injury management. An initiative to reduce falls by increasing exercise is in the process of being reintroduced after a reduction in residents’ participation.  Interview with the visiting speech language therapist, verifies satisfaction with the facility’s management strategies in relation to managing residents with speech/language and swallowing difficulties. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services are able to be accessed when required. Staff knew how to do so, although reported this was rarely required due to most residents being able to speak English, a wide range of staff from varying cultures being available, the use of family members, and the availability of communication cards for the few residents for whom English is not their first language or aphasia is a problem. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Anglican Care Waiapu, Board of Directors have developed a strategic plan that outline the purpose, values, scope, direction and goals of the organisation. This is used by each facility to develop a business plans, which is signed off by the regional operational manager. These are reviewed annually. These documents describe annual and longer term objectives and the associated operational plans. The facility manager receives reports from senior staff which informs their monthly report to the regional operations manager. These reports are templated and provide evidence against the objectives to and key performance indicators. The information provided then goes to the Board. A sample of reports reviewed shows adequate information to monitor performance is reported including, quality and risk, financial, complaints, health and safety.  The service is managed by a facility manager who has a degree in psychology, and has been a manager in a health related service for a number of years. This is her first position in residential care and she has been in the position since November 2015. Orientation to this role included a week of training and working with the regional operational manager, who continues to offer support, as well as support from the organisational clinical quality and compliance manager. Responsibilities and accountabilities are defined in a job description, individual employment agreement and delegated authorities policy. The facility manger and clinical quality compliance manager confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through attending conferences and updates from the Ministry and New Zealand Aged Care Association. The facility manager is supported by the clinical manager who is a registered nurse. The clinical nurse manager has been in her position for five years, due to the change of facility manager to a non registered nurse the clinical nurse manager had had increased responsibility which she is states is challenging at times.  The service holds contracts with Bay of Plenty DHB for rest home, respite, hospital and palliative care residents. Fifty eight residents receive services under the contracts. On the day of audit there were 21 rest home and 36 hospital beds (including two palliative care) occupied.  The prospective owner’s (HLL) provide aged related services and management services to other service providers presently and have a working knowledge of the contracts the present owner has with the district health board. The clinical quality and compliance manager provided evidence of planning for the transition and stated that the structure within the facility would remain unchanged, including registered nurse full time equivalents. The Bay of Plenty DHB and the Ministry are aware of the plan to purchase this service. |
| Standard 1.2.2: Service Management  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. | FA | When the facility manager is absent, the clinical nurse manager carries out all the required duties under delegated authority. They are supported by the clinical quality and compliance manager and the regional operations manager. During the absences of the clinical nurse manager another senior registered nurse would oversee the facility. They are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.  The HLL quality and compliance manager stated that they will continue with the present management structure and arrangements including contingencies when senior staff are not available. |
| 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. | FA | The organisation has a quality and risk system that is overseen by the Anglican Care Waiapu clinical quality and compliance manager and delegated to a facility quality coordinator who is an enrolled nurse, who is full time in this role and has a job description that outlines their responsibilities. The quality and risk plan reflects the principles of continuous improvement and was understood by the staff spoken with. This includes the management of incidents and complaints, annual audit activities, a regular family satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls and skin tears.  There is a quality and risk, infection control, health and safety meeting, monthly. The minutes of these meetings confirmed adequate reporting systems and discussion occurs on quality matters including pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Organisational quality coordinator meetings occur quarterly to allow for education and discussion on quality issues. Monthly reports go to the clinical quality and compliance manager and the facility manager, this allows for regular review, analysis and trending of quality indicators to occur. There was evidence of corrective actions being undertaken and carried forward to the next meeting for follow through. Minutes of staff meetings showed that staff are informed of quality issues and this was confirmed by staff spoken with. Resident meetings occur regularly and family surveys are completed annually. The last survey showed overall satisfaction with the service provided and narrative comments were discussed with the manager to ensure actions are taken where necessary and where negative comments identified then a complaints process is followed.  Policy development, review and document control is undertaken by the clinical quality and compliance manager and covers all necessary aspects of the service and contractual requirements. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents by delegated staff members at each facility. A few policies were identified as being past their review date and the clinical quality and compliance manager was able to provide evidence that these are under review and out for discussion, this included health and safety and restraint minimisation. Staff are updated on new policies or changes to policies through Time Talk (staff electronic time in and out system), notices, a folder for this purpose and at staff meetings. This was confirmed by staff spoken with and minutes of staff meetings.  The clinical quality and compliance manager and facility manager provided evidence via the organisational strategic plan of the identification and mitigation of strategic risks. These are reviewed annually as part of the review of the document. The quality coordinator undertakes the role of health and safety officer and has undertaken training relevant to the position, including in the Health and Safety at Work Act (2015). They described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of risks at each monthly meeting and annual review of the full register. New risks are added to the register as requirements. Anglican Care Waiapu has been assessed by Accident Compensation Corporation (ACC) Partnership Programme as meeting tertiary level compliance.  HLL have a corporate quality and risk management plan which includes an audit schedule, clinical indicators and policies and procedures that meet the requirements of the standard and contract requirements. They plan to look at the current Anglican Care Waiapu plans and work towards a combination of both processes. |
| 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 | Staff document adverse and near miss events on an incident form. This was confirmed by staff during interview. There are processes in place to ensure incidents are managed promptly and reported to the registered nurse promptly, a form completed and sent to the quality coordinator for follow up including investigation. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed, including by type and resident, and reported via reports to the clinical quality and compliance manager and the facility manager. Minutes of the quality and risk, infection control and health and safety meeting reviewed showed discussion in relation to trends, action plans and improvements made.  The clinical quality and compliance manager, facility manager is informed of any issue which requires reporting to an external body. This includes pressure injuries, health and safety events, human resources, infection control, the Coroner and the DHB. The facility manager and clinical quality and compliance manager advised there have been notifications of significant events made to the Ministry of Health. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Policies and procedures reviewed are in line with good employment practice and relevant legislation and guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. This process was confirmed by the facility manager. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are systematically maintained. An issue has been identified with the employment of a registered nurse who did not fully disclose competency issues at the interview stage. This is being formally managed by the organisation and the nurse. Annual practising certificates were seen as current for all enrolled and registered nurses, the physiotherapist, pharmacist and GP.  The quality co-ordinator provided evidence of role specific orientation workbooks that includes all necessary components relevant to legislation, these standards, contract requirements and good practice. Staff reported that the orientation process prepared them well for their role and included support from a ‘buddy’ through their initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.  The clinical quality and compliance manager confirmed that continuing education is planned on an annual basis. The organisation defines mandatory training including the completion of a number of competencies, such as restraint, manual handling, infection control and medication. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The quality coordinator is a Careerforce internal assessor for the programme and a registered nurse has also applied to be an assessor. The organisation policy is to have all caregivers undertake dementia training as many residents in the other areas have a degree of dementia. This also facilitates staff deployment across the whole facility. Education records reviewed demonstrated completion of the required training including palliative care courses and use of pump syringe drivers. Staff interviewed confirmed continuing requirements to attend training. The annual appraisal process for staff in general is undertaken by the clinical nurse manager; a number were outstanding at audit. |
| 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 policy on staffing mix that covers the contractual requirements and includes the rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The clinical nurse manager is responsible for the rostering of staff. The minimum number of staff is provided during the night shift and consists of one registered nurse and two caregivers. There is a roster of senior staff who are on call with that include registered and enrolled nurses and the facility manager. The clinical staff will also be called if a clinical matter arises while the facility manager is on call. Staff report good access to advice is available when needed. The review of the two-week roster cycle sampled over four weeks confirmed adequate staff cover has been provided.  Residents and family interviewed and observation during the audit confirmed that staff are providing services required of them.  The prospective owner’s quality and compliance manager is aware of the contracts the facility has and the staffing requirements within these and stated that the present roster system would remain in place. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The admission agreement was sighted and discussion with the facility manager identified that they have only one hospital level care room that does not incur a premium surcharge. The facility manager stated that residents and their family are made aware of this before agreeing to admission. She spoke of some residents who are unable to pay the extra being given a reduced rate or not being charged the premium surcharge. No one has been turned away who could not afford the premium rate and residents and family members are made aware of other facilities in the area who would not charge a premium rate for hospital level rooms.  Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with clinical manager (CM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updated information for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the organisation’s transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed a planned and co-ordinated approach. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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 | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. On the day of audit, sighted controlled drug administration did not comply with best practice and a safe medication management system.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.  There are no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.  Standing orders are used, are current and comply with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  The service operates with a food safety plan that was audited internally in March 2016 and verified as compliant, however some aspects of food preparation and storage are not compliant with current guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager is a qualified chef and has undertaken safe food handling qualifications, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and the interRAI assessment, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Plans reviewed reflected the general support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant, however interviews, evidence and documentation is unable to support this occurs consistently particularly in the case of residents with more complex needs. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, with the exception of that identified at 1.3.5.2. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of an acceptable standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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 | The activities programme is provided by two trained diversional therapists (DT) holding the national certificate in diversional therapy, and an activities assistant in the process of training as a DT.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as residents needs change and as part of the formal six monthly care plan review.  The planned monthly activities programme sighted offers a large range of varied activities that match the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include a knitting group that knits for orphanages, cancer clients and the neonatal unit, a walking group, a foundry group, a man’s group and the rainbow club. Outings occur on a regular basis as does attendance by visiting community groups. The activities programme is discussed at the residents’ meetings and minutes indicate residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme very enjoyable, with lots going on. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of health variation (short term) care plans were consistently reviewed and progress evaluated as clinically indicated (daily, weekly or fortnightly) and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances were in place, including segregation of waste, recycling and detailing procedures for blood and bodily fluids management and disposal.  Chemicals were seen stored in locked areas around the organisation with the bulk being in an outside garage. The ‘handy man’ undertakes the dilution of chemicals where required and has undertaken training in chemical management. It was observed that two chemicals were being used outside the organisation wide policies. The dilution was not on the containers and material safety data sheet was not available for one chemical. The clinical quality and compliance manager removed one chemical and a new facility specific policy was put in place for the other plus the material data sheet was downloaded from the internet. Training on the new policy has been scheduled following the audit.  An external company is contracted to supply and manage the majority of chemicals used for cleaning and in the laundry. The company provide relevant training for staff. This was sighted in a sample of cleaning and laundry staff files. Material safety data sheets were available for the chemicals provided by the external company and are stored safely. Staff interviewed knew what to do should any chemical spill/event occur and state they would report any related incidents in a timely manner.  There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves (including acetate for dilution purposes), masks, face shields and plastic aprons. |
| 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 expires January 2017 and is displayed in the reception area. There is a proactive maintenance programme and reactive maintenance is by the use of a diary in each area to log maintenance issues. The testing and tagging of equipment is undertaken by the handyman who is a registered electrician. The calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the quality coordinator and observation of the environment. One mobility scooter is in use and is stored indoors but it does not pose a hazard to other residents. The path used by the scooter was seen as steep and the organisation should consider if this is the most appropriate access and exit from the facility for the resident.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose.  External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Staff interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned. Residents interviewed and family satisfaction surveys results show that they are happy with the environment.  The prospective provider has no plans to make changes to the present environment of this facility. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites, toilets shared between two rooms, and additional bathrooms and showers. Toilets are also located near activity areas. An adequate numbers of accessible bathrooms and toilets are identified throughout the facility. Staff and visitor toilets are available and are separate from residents’ toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. The facility should consider using signs of an appropriate size on communal toilet and showers to ensure privacy for patients, as presently the locks are used and these are small and the writing has worn away on some. Staff report there has been no complaint or incident related to the privacy of residents using these facilities. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | and were observed to be personalised by each resident and family. Some have their own furnishings, photos and other personal items displayed. Some rest home rooms are small but adequate for rest home residents and some superficial repainting/varnishing is required. The facility manager stated that there are plans to refurbish these and make some ensuites. Hospital level care rooms are larger and have doors that open to one plus half size which allow for ease of use of hoists. Adequate personal space is provided to allow residents and staff to move around within the bedrooms safely including with the use of mobility aids.  There is room to store mobility aids walking frames and wheel chairs. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | A number of communal areas are available for residents to engage in activities with a bowls room with a raised bowls table which is reported as being very well utilized. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is undertaken on site in a dedicated laundry, this includes resident’s personal items. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently managed by dedicated laundry staff. The processes were observed and meet good practice. Laundry staff were able to demonstrate that they follow procedures on washing and drying cycles, dirty/clean flow, handling of soiled linen and have been given training on chemical management.  There is a small designated cleaning team who cover seven days a week and have received appropriate training. Chemicals were stored in the sluice rooms which are lockable and on cleaning trollies which cleaning staff are able to say should not be left out of their sight. All containers were labelled with the manufacturers labels. Cleaning and laundry processes are monitored through the internal audit programme and by the chemical company representatives. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | All laundry is undertaken on site in a dedicated laundry, this includes resident’s personal items. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently managed by dedicated laundry staff. The processes were observed and meet good practice. Laundry staff were able to demonstrate that they follow procedures on washing and drying cycles, dirty/clean flow, handling of soiled linen and have been given training on chemical management.  There is a small designated cleaning team who cover seven days a week and have received appropriate training. Chemicals were stored in the sluice rooms which are lockable and on cleaning trollies which cleaning staff are able to say should not be left out of their sight. All containers were labelled with the manufacturers labels. Cleaning and laundry processes are monitored through the internal audit programme and by the chemical company representatives. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas have opening external windows. Heating is provided by hot water radiators which have covers and were observed to be of a temperature that would not burn if touched by residents. The temperature of the facility is monitored. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  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. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from an external advisor. The infection control programme and manual are reviewed annually.  The quality co-ordinator and one of two care co-ordinators are the two designated IPC coordinators, whose roles and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM, FM and the organisation’s quality risk manager and tabled at the quality meetings. The quality committee includes the FM, CM, IPC coordinators, the health and safety officer, and representatives from food services and household management.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation | FA | The infection prevention and control coordinators have appropriate skills, knowledge and qualifications for the role. They have undertaken training in infection prevention and control and attended relevant study days and IPC conferences, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisor is available if additional support/information is required. The coordinators have access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinators confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  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. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2015 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinators. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the electronic resident management system/infection reporting form/clinical record. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, quality committee and at staff meetings. Data is benchmarked internally within the group. Benchmarking has provided assurance that infection rates in the facility are below average.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.  There have been no recent outbreaks in the past two years. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The facility follows the suite of policies and procedures developed by Anglican Care Waiapu and these are currently under review. These meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical nurse manager (CNM) is the restraint coordinator. The policies show that the same process is used to document and monitor the use of restraints and enablers. The CNM‘s interpretation is that they don’t use enablers. The organisation should consider further education related to this process. There is a restraint coordinator job description which details the role and responsibilities.  On the day of audit, 14 residents were using restraints and some were also using enablers, as described by the CNM. An example of one residents who is an amputee who had bed rails at night and a lap belt during the day while in his wheelchair was reviewed. The documentation related to this resident shows these have been considered by staff and are the least restrictive and used voluntarily at the resident’s request. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.  Restraint is used as a last resort when all alternatives have been explored and use ceased when review identifies it is no longer required. This was evident on review of the restraint approval group minutes and files reviewed of those residents who have approved restraints and from interview with the CNM. |
| 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. | FA | The restraint approval group is made up of the CNM, a registered nurse and an enrolled nurse. The group are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meeting minutes, review of residents’ files and interview with the CNM that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.  Evidence of family who have Enduring Power of Attorney (EPOA) involvement in the decision making, as is required by the organisation’s policies and procedures, was on the restraint consent form in each resident’s file where restraint was in use. The lifestyle care plan includes documented restraint use and risks associated with the use of these. |
| Standard 2.2.2 Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint is documented on an assessment form that included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the sign off by the CNM, and input from the resident’s family with EPOA. The CNM described the documented process. The GP signs off the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed assessments were sighted in the records of residents who were using a restraint and all were signed appropriately within a tight timeframe. |
| Standard 2.2.3 Safe Restraint Use  Services use restraint safely | FA | Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, hourly monitoring occurs to ensure the resident’s cares are being met with recording of toileting, food and drink being given and that the resident remains safe. The monitoring form is kept in the resident’s file and used by the restraint group for monitoring and to identify if restraint is still required. This was seen completed in four residents’ files with restraint in use. Residents were observed with the use of bed rails in use and it was seen that all processes ensure dignity and privacy being maintained and respected.  A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed for July and August and showed a reduction in the number of residents with the use of restraint. At each monthly meeting all residents currently using a restraint are reviewed.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraints is to be minimised and how to maintain safe use was confirmed. |
| Standard 2.2.4 Evaluation  Services evaluate all episodes of restraint | FA | Review of residents’ files (four) evidenced the individual use of restraints is reviewed and evaluated monthly by the restraint group, and six monthly as part of the lifestyle care plan and interRAI reviews, with input from family and documented evaluations by the GP.  The evaluation includes all requirements of the Standard, and in some cases future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5 Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint | FA | The restraint committee review all restraint use on a monthly basis, which includes all the requirements of this Standard. Minutes of the restraint group meeting confirmed analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and the appropriateness of restraint / enabler. Restraint use is reported to the quality meetings and is an item on the staff meeting agenda. Any changes to policies, guidelines, education and processes are implemented if indicated. |

# 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)** |
| 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumer | PA Low | The annual appraisal process has been undertaken by the clinical nurse manager since November 2015. She has been working on putting a system in place to ensure all appraisals are current. The clinical nurse manager has developed a folder with a month by month register of who is due, plus there is a spreadsheet which is not current. It was identified that a number of appraisals were still to be completed. | A computerised spreadsheet showed approximately 27 percent of performance appraisals are outstanding, however the spreadsheet was out of date and the clinical nurse manager was able to show that the correct total outstanding was approximately 10 percent, plus some that were partially completed (ie, completed by the staff member but the interview was outstanding). A review of ten staff files identified that six had not occurred in the last 12 months. | All staff have a current annual appraisal.  180 days |
| 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Documentation, interviews with a RN, the CM and nursing staff and observation of nursing practice verified lifestyle care plans reviewed reflected the resident’s general support needs, however there were noticeable gaps in four of eight care plans reviewed around more complex needs and interventions. Residents with a documented medical condition on assessment had no nursing interventions documented to monitor the resident and manage the condition to ensure the required support was being provided. This has the potential to prevent early detection of potential deterioration in the resident’s condition. | Lifestyle care plans, do not always describe fully the required support required to meet the residents’ assessment finding. | Service delivery plans describe fully all required support needed, as identified in the assessment process.  90 days |
| 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 | The system of medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Observation, interview and sighted documentation verified a controlled drug was checked out of the controlled drug cupboard by two RNs, including completion of documentation in the controlled drug register. The medication was sighted in the locked medication trolley during an observed medication round. Interview with the RN responsible for the medication round verified the controlled drug was to be given to the resident at a later stage, and the second RN who checked the medication would come and observe it was administered to the right resident. Interview with the second RN verified this was the case. Interviews with both RNS verified this was not a one off event for these nurses. Interview with the clinical manager confirmed this practice was not consistent with policy and observed competency assessments. | The management of controlled drug administration is not in line with best practice guidelines or safe medicine management. | The management of controlled drugs is in line with best practice  90 days |
| 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA  Moderate | The food service is provided by an external provider and operates with a food safety plan. The kitchen and pantry contain numerous areas where food preparation and storage is unsuitable for purpose. Areas identified include the worn linoleum flooring, chipped delaminated shelving exposing wooden surfaces and chipped Formica on the walls. The cleaning schedule was sighted, however interviews observation and documentation is unable to verify compliance. The temporary chiller being used while a new one is constructed, has food scraps on the floor and ice build-up. Foods decanted into other containers have no verification of use by dates. | Some aspects of food preparation and storage are not compliant with current guidelines. | Ensure all aspects of food preparation and storage meet current guidelines.  90 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.

End of the report.