# FOMHT Health Services Limited

## Introduction

This report records the results of a Partial Provisional Audit; 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 Central Region's Technical Advisory Services 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:** FOMHT Health Services Limited

**Premises audited:** Jack Inglis Friendship Hospital

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

**Dates of audit:** Start date: 22 November 2016 End date: 23 November 2016

**Proposed changes to current services (if any):** A reconfiguration was requested by the facility to use all 28 rest home beds as dual purpose beds and a partial provisional audit was required. A further reconfiguration was subsequently requested by the facility for an increase of five beds in the dementia unit and a reduction of five hospital beds, which required review at this audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 71

# 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

A surveillance and partial provisional audit was undertaken to monitor compliance with the streamlined Health and Disability Services Standards criteria and the district health board contract. Jack Inglis Friendship Hospital is operated by the Friends of Motueka Hospital Trust Health Services Limited. The service provides hospital, rest home and dementia care. Occupation on the day of the audit was 71 residents.

The audit process included review of policies and procedures, sampling of resident and staff files, observations, interviews with residents and their families, management, staff and general practitioners.

The partial provisional audit was undertaken to establish the level of preparedness of the facility to provide reconfigured services with changing 28 rest home beds to dual purpose beds. An additional reconfiguration request to increase the dementia service beds by five, which involves moving the security doors along the corridor, was reviewed. Both proposed changes will not adversely affect the facility’s ability to deliver appropriate care or services to residents.

The previous partial attainment has been achieved. There is a new partial attainment in medication management.

## Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Information (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are accessible. This information is given to residents and their families on admission to the facility. Residents and family interviewed confirmed their rights are met. The manager is responsible for management of all complaints. Interviews with residents and families confirmed that staff are respectful of residents’ needs and communication is appropriate.

## Organisational management

Friends of Motueka Hospital Trust Health Services Limited is the governing body and is responsible for the service provided at Jack Inglis Friendship Hospital. The manager is qualified and experienced. There is a clinical manager and two clinical leaders responsible for oversight of clinical care. Quality improvement data is collected, collated, analysed and reported through the quality management system. Risks are identified and the hazard register is up to date. Adverse events are documented on incident and accident forms and areas requiring improvement are identified.

Policies and procedures relating to human resource management govern practices. Staff records reviewed provided evidence that human resource processes are followed. Staff education records confirmed in-service education is provided. A documented rationale for determining staffing levels and skill mix is implemented to reflect the resident’s acuity to ensure the correct allocation of nursing staff is applied and is considered appropriate for both proposed reconfiguration changes to the service. There is an orientation programme for all new staff to complete.

The manager, the clinical manager and the clinical leaders are available after hours, if required, for clinical support. Care staff, residents and family report that there is adequate staff available.

## Continuum of service delivery

Initial care plans are used as guidelines for all staff while the long-term care plans are developed over the first three weeks after admission. Care plans are individualised. Risk and InterRAI assessments are completed. Residents’ response to treatment is evaluated and documented. Care plans reviewed were evaluated six monthly. Relatives confirmed being notified regarding changes in a resident’s health condition.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. Residents and families expressed their satisfaction with the activities provided by the diversional therapist and the activities coordinator.

Medicine management policies and procedures are documented. The general practitioners completed regular and timely medical reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications.

Menus are reviewed and residents’ individual food and fluid provision are in line with recognised nutritional guidelines appropriate to the consumer group.

## Safe and appropriate environment

Residents' rooms have adequate personal space. Lounges and dining areas are available for residents and external areas are available for sitting. Shade is provided. The environment is considered suitable for the proposed changes to the service.

The facility has a call bell system in place. The service has security systems in place to ensure resident safety. Sluice facilities, protective equipment and clothing are provided and used by staff. The on-site laundry facility provides a full linen service for the facility.

Chemicals, linen and equipment are safely stored. The service has a current building warrant of fitness. The preventative and reactive maintenance programme includes equipment and electrical checks.

## Restraint minimisation and safe practice

The facility actively minimise restraint use. The restraint minimisation programme defines the use of restraints and enablers. The restraint register showed only enabler use. Visual inspection and interviews confirmed that there were no restraints used at the time of the audit.

## Infection prevention and control

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data reviewed was collected monthly for benchmarking. Appropriate interventions are in place to address the infections.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 25 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 59 | 0 | 0 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **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 service has systems in place to manage complaints. The complaints process records a summary of the complaint, the investigation and outcome. All complaints reviewed had resolution and documentation to support closure. Systems are in place to ensure residents and their families are advised on entry to the facility of the complaint processes and the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Information (the Code). The complaint process was readily accessible and complaints forms are displayed for easy access. Residents and family interviewed confirmed having an understanding and awareness of these processes.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure policy and procedures are in place to ensure staff maintain open and transparent communication with residents and families. Communication with family members is documented in residents' records. There is evidence of communication with the general practitioners (GP) and family following adverse events. Staff interviews and documentation confirmed that there is access to interpreter services available through the district health board if required.Residents interviewed confirmed that staff communicate effectively and residents are aware of the staff responsible for their care. Admission agreements reviewed were signed and dated on admission. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Jack Inglis Friendship Hospital’s vision, values, mission statement and philosophy are displayed at the entrance to the facility, in booklets and is also included in staff training provided annually. The organisation records their scope, direction and goals in their business, strategic and quality plans. A process is in place to ensure currency of documents. The manager provides monthly reports to the board. Reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators. The manager has worked in this role for three years, has experience in other aged care services as a facilities manager and has a Marsters of Business Administration. On the day of the audit occupancy was 71, with 27 rest home, 31 hospital, 10 dementia, 1 respite, 1 palliative and 1 acute general practice level resident. |
| 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 | There are appropriate systems in place to ensure the day-to-day operation of the service continues if the manager, clinical manager (CM) and clinical leaders (CL) are absent. Where possible the manager, CM and CLs are not scheduled leave at the same times. The CM with support of the clinical quality manager provides cover when the manager is absent. The manager confirmed their responsibility and authority for these roles. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Jack Inglis Friendship Hospital (JIFH) has a documented quality and risk management framework to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. Policies are linked to the Health and Disability Service Standards applicable legislation, and evidenced based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to sign after they have read each policy. A quality improvement plan with quality objectives are used to guide the quality programme. Family, resident and staff satisfaction surveys are completed as part of the audit programme and collated for improvement purposes. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme. Corrective action plans are documented and resolution of issues are completed. There is collection, collation, and identification of trends through analysis of data.There are a variety of meetings held to discuss data. These include monthly staff/quality meetings, clinical meetings and health and safety meetings. Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. Staff report that they are kept informed of quality improvements and can have input into discussions and review of service delivery. All meetings have an agenda and minutes are maintained with the identification of people responsible for outcomes and timeframes. Staff are informed of clinical indicators and quality improvement data at staff meetings.JIFH has a policy and rationale in place to implement the reconfiguration of 28 dual purpose beds and 5 additional dementia beds. |
| 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 | The manager is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, infectious disease outbreaks, and changes in key managers. JIFH has a current coroner’s enquiry open.Staff document adverse, unplanned or untoward events on an accident/incident form. Incident and accident forms are reviewed and signed off by the clinical leaders. Incident reports documented had a corresponding record in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed, with evidence of improvements put in place. Incident and accident records include pressure injuries. Staff confirmed during interviews that they are made aware of their responsibilities for completion of adverse events. The service follows the organisation’s policy regarding the management of incidents. |
| 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 | Written policies and procedures in relation to human resource management are available and implemented. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Completed orientation and annual clinical competency assessments are filed in staff records. The registered nurses (RN) hold current annual practising certificates along with other health practitioners involved in the service. An annual performance appraisal schedule is in place and current staff appraisals were sighted on staff files reviewed.The organisation has a nurse educator role composing of 0.4 full time equivalent (FTE) who works with the quality manager and is responsible for the in-service education programme. Staff are supported to complete education through external education providers, including the ACE training programme. The service has an annual training schedule. Staff attendances of training sessions are documented. Education and training hours are at least eight hours a year, for each staff member. All staff working in the dementia unit are expected and supported to complete training specific to working in dementia care, within required timeframes. Three RNs are trained in InterRAI.There is a policy in place to support the increase in acuity and to escalate staffing cover when required, ensuring an appropriate skill mix. Current staffing numbers, skills and competencies are sufficient for the proposed changes. Additional dementia training is planned and additional staff expected to be recruited. Currently two RNs are on the day shifts not including the CM and two CLs, and one on the night shift.  |
| 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 and rationale in place for determining service provider level and skill mixes in order to provide a safe service delivery. Rosters were reviewed and there is sufficient staff cover to provide current services and a plan to increase staffing acuity levels, as required, in a responsive manner to manage the proposed reconfiguration changes.Registered nurse (RN) cover is provided 24-hours a day. There are clinical leaders on duty five days a week to support the RNs, including after hours on call.  |
| 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 | Medication areas, including controlled drug storage, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stocktakes by the pharmacist. The medication fridge temperatures are monitored and recorded. Current medication competencies for staff who administer medicines were sighted; however, there is a requirement for improvement relating to medication management competency due to incorrect processes being witnessed during the medicines management round. Administration records and specimen signatures are maintained. Medical and medicines reviews by the GPs were up to date. The service implemented an electronic medicines management system.Medication audits have been conducted and corrective actions are implemented following the audits. There were no residents self-administering medicines at the time of the audit. The reconfiguration of services to include 5 more beds in the dementia unit and change 28 rest home beds to dual purpose beds will not affect the service’s ability to provide appropriate medicines management services to residents. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service provider was interviewing at the time of the audit to appoint a new chef. Interview with the cook confirmed kitchen staff have completed food safety training. This was verified by food safety certificates. In interview, the cook confirmed residents’ individual dietary needs are identified on residents’ admission. The residents' files demonstrate monthly monitoring of individual residents’ weights. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided. On inspection, the kitchen environment was clean, well-lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures.There is a seasonal menu, last reviewed by a dietitian in August 2016. Review of residents’ files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals. Meals for special diets and pureed meals, along with alternative nutrition appropriate to the residents, are available. There was enough stock to last in an emergency situation, for three days, for residents and staff.The service provided additional food and fluids for when residents in the dementia unit are hungry in between mealtimes. The reconfiguration of services to include 5 more beds in the dementia unit and change 28 rest home beds to dual purpose beds will not affect the service’s ability to deliver food services. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Resident file reviews and interviews confirmed residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. Long-term care plans include goals and interventions to support achievement of goals. Person specific needs including pain management, mobility needs, dietary likes and dislikes, are included in assessments and the long-term care plans.Allied health services in the long-term care plan include: the speech language therapist services, dietitian services, occupational therapy, needs assessment service coordinators (NASC) and physiotherapy. Interviews with the GPs confirmed clinical interventions are effective and appropriate.Multidisciplinary meetings are conducted by the clinical leader or the clinical manager to discuss and review long-term care plans and changes in the needs of the resident. Residents and family involvement in the development of goals and review of care plans is encouraged. All resident files reviewed were signed by either the resident or by their family. Staff members working in the dementia unit completed the required training of unit standards relating to dementia care prior to being employed to the unit.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 programmes are coordinated by a diversional therapist (DT) and an activities coordinator (AC). Interviews with the DT and AC confirmed that independence is encouraged and choices are offered to residents. The programmes provide different activities addressing the abilities and needs of residents in the hospital, rest home, dementia care and day care. Residents under the age of 65 have additional activities to ensure their specific needs, especially social needs, are met. The service had one resident under the age of 65 at the time of the audit.Activities include: physical, mental, spiritual and social aspects of life to improve and maintain residents’ wellbeing. During the on-site visit, activities included residents going for an outing, music and one-on-one activities. Each resident had their own copy of the programme. All resident files reviewed during the on-site audit had current activity assessments in place.Residents and family interviews confirmed they enjoy the variety of activities and are satisfied with the activities programme. The reconfiguration of services to include 5 more beds in the dementia unit and change 28 rest home beds to dual purpose beds will not affect the service’ ability to deliver appropriate activities to residents. The service has appropriate space available to safely provide activities for five more residents with dementia in the dementia unit.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents’ progress records are entered on each shift. When a resident’s progress is different than expected, the RN contacts the GP, as required. The family are notified of any changes in resident's condition, confirmed at family interviews. Clinical reviews are documented in the multi-disciplinary review (MDR) records, which include input from the GP, RNs, caregivers, AC, DT and other members of the allied health team. Additional reviews include the three monthly medication reviews by the GPs.Short-term care plans are developed for acute problems for example: infections, wound management, pressure injuries, falls and other short-term conditions.  |
| 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 are in place and the hazard register is current. Policies and procedures specify labelling requirements are in line with legislation, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff confirmed they receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of personal protective clothing and equipment including: goggles/visors, gloves, aprons, footwear, and masks. During the tour of the facility, personal protective clothing and equipment was observed in areas where there were risks.The service’s management of waste and hazardous substances is sufficient to meet the organisations needs as proposed by the reconfiguration of services for additional dementia beds and change to dual beds. |
| 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. There have been no building modifications since the last audit. The service has a planned maintenance schedule implemented with an annual test and tag programme. This is up to date with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirm there is adequate equipment, currently and for the proposed reconfiguration, including: pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There are quiet areas throughout the facility for residents and visitors to meet, providing privacy, when required. There are two large courtyards and lawn areas, one of the courtyards is part of the dementia secure unit which has been designed specifically for residents to access safely. Both areas have shade, seating and outdoor tables. The secure unit for residents identified as requiring dementia care is accessed through touch pads and key pads. The building is single storey and the main entrance is covered which provides shelter for access. There are no entries with steps. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their own ensuite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.As there is no increase in the number of beds, there are sufficient toilets and bathing facilities to accommodate the needs of residents with regard to the reconfiguration of dual service beds and additional dementia beds. |
| 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 | There is adequate personal space provided in all bedrooms to allow residents and staff to safely move around within the room. Equipment was sighted in rooms with sufficient space for equipment, for example; hoists, and at least two staff and the resident. Rooms are personalised with furnishings, photos and other personal adornments. The service encourages residents to make the suite their own.There is room to store mobility aids, such as walking frames, in the bedroom safely during the day and night if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has lounges and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. The three dining areas have ample space for residents and will meet the requirements for the planned reconfiguration for dual purpose beds and the increase of five dementia beds. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The laundry services are completed on site. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. The linen trolleys are clearly labelled to identify residents’ individual laundry and general laundry. The laundry staff interviewed confirmed knowledge of their role, including management of any infectious linen.There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaning and laundry audits confirmed an effective monitoring process is implemented. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan was approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food, water; blankets; emergency lighting and gas barbecues. An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells.All external doors are locked after sunset. Staff complete a check in the evening that confirms that security measures are in place. |
| 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 | Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area for residents. Family and residents confirm that rooms are maintained at an appropriate temperature. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever possible. |
| Standard 3.1: Infection control managementThere 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 responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The infection control committee has representatives in each area of the service management team. This group meets quarterly and infection control matters are discussed at the monthly staff/quality meetings. There is an infection control programme that was last reviewed at the end of January 2016. When a resident presents with an infection, staff send specimens to the laboratory for sensitivity testing. The GP prescribe antibiotic as per sensitivity, confirmed during interview. The RNs create a short-term care plan and review the effectiveness of the prescribed antibiotics when the treatment is completed. Infections are discussed during staff meetings, sighted meeting minutes.The reconfiguration of services to include 5 more beds in the dementia unit and change 28 rest home beds to dual purpose beds will not affect the service’s ability to deliver safe and appropriate services relating to infection prevention and control. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organisation. Surveillance is aligned with the organisation’s policies. Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, infection control and health and safety meetings. The infection control coordinator (ICC) is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff meetings.Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents’ files. In interview, the ICC confirmed no outbreak had occurred at the facility since the last audit. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Should restraint needed to be used at any time, there are policies and procedures to follow. The definition of restraint and enabler is congruent with the definition in the standard. The service has a focus on restraint minimisation and safe practice. There are documented processes for assessment, care planning, monitoring and evaluation of restraint and use; should they need to use restraint. The restraint assessment form used by the service to identify residents that may or may not need restraint includes all required areas of the standard.There is a job description for the position of the restraint coordinator. No restraint or enabler use was witnessed during the visual inspection of the service.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service does not use any restraints and there is therefore no need for rigorous assessment of residents in relation to restraint use. The previous requirement for improvement relating to identification of restraint risks has been implemented. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.3Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | The service provider completes annual competency testing of all staff who administer medicines. During the medicines round in the rest home, the person responsible for the administration of medicines did not follow medicines management guidelines regarding sign-off of medicines. The staff member signed four of six medicines off prior to administration.  | Medicines management guidelines for sign-off of medicines after administration were not followed.  | Ensure all staff adhere to medicines management guideline requirements. 60 days |

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

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

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

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

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End of the report.