# Forrest Hill Continuing Care Limited - Forrest Hill Home and Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Forrest Hill Continuing Care Limited

**Premises audited:** Forrest Hill Home and Hospital

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

**Dates of audit:** Start date: 10 January 2017 End date: 11 January 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 59

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Forrest Hill Home and Hospital is privately owned. It offers hospital and rest home level care services for up to 62 residents.

This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, families/whānau, one general practitioner, management and staff.

There is one area identified as requiring improvement related to documentation of competencies for health care assistants who undertake medication management.

## Consumer rights

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

Staff demonstrated good knowledge and practice of respecting residents’ rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents interviewed expressed high satisfaction with the caring manner and respect that staff show towards each resident.

There are no known barriers to Maori or residents who identify with different cultures accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents’ family/whanau, enduring power of attorney (EPOA) or appointed guardians.

Residents are encouraged and supported to maintain community and family links.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaint register and the information is recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The organisation's philosophy, mission and vision statements are identified in policy. The governance structure is identified in the business plan. The directors ensure service planning covers business strategies for all aspects of service so the services offered meet residents’ needs, legislation and good practice standards. The general manager, oversees all day to day activities at the facility and meets with a director at least once every two weeks. Fortnightly written reports are presented to the directors to show service efficiency against set key performance indicators and quality and risk management processes. Issues of a serious nature are reported to the directors immediately.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident/family/whanau surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and families/whānau, as appropriate. Corrective action planning is documented. Incident and accident management occurs to meet policy requirements; this includes reporting of adverse events to appropriate authorities. Forrest Hill Home and Hospital holds Accident Compensation Corporation (ACC) tertiary level status for safe work management practices.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. Residents and families/whānau confirmed during interview that all their needs and wants are met. The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements. Consumer information is uniquely identifiable, accurately recorded, current, confidential and accessible when required.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents on admission to the service are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. When there are changes to the resident’s needs a short-term plan is developed and integrated into a long-term plan. The service meets the contractual time frames for short and long term care plans. Care plans are evaluated at least six monthly.

Residents are reviewed by their general practitioner (GP) following admission, and assessed thereafter either monthly or three monthly depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

The Life Style staff (activities) provide planned activities meeting the needs of residents as individuals and in group settings. Families reported that the activities are appropriate and they are encouraged to participate.

Medicine administration system was observed at the time of audit and met safe and good practice standards

The onsite kitchen caters for residents with food available 24 hours of the day, with specific dietary, likes and dislikes met. The service has a four-week rotating menu which is approved by a registered dietitian. Residents’ nutritional requirements are met.

## Safe and appropriate environment

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

The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

There are documented emergency management response processes which are understood and implemented by staff.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit.

The facilities meet residents’ needs and provide furnishings and equipment that is regularly maintained and updated. All but one bedroom is single occupancy. The one double bedroom is only used for couples who choose to share a room. There is adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility is adequately heated throughout and there are opening doors and windows in all resident areas to create a good air flow. The outdoor areas provide furnishings and shade for residents’ use. Residents and family/whānau were happy with the environment provided.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of the audit, the service has five enablers and 10 restraints in use which are all bedside rails. This was confirmed in the restraint register sighted.

Policies and procedures are implemented by staff to ensure safe restraint use is maintained. This includes assessment and monitoring processes.

All restraint is for safety reasons only. Staff education occurs annually and was last presented in July 2016. Staff verbalised their understanding and knowledge related to safe restraint management.

All restraint is evaluated monthly at the registered nurses meeting, three monthly by the restraint coordinator and six monthly with resident and families/whanau.

## Infection prevention and control

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

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents.

There is a monthly surveillance programme, where infections information is collated, analysed and compared with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported and discussed at staff and resident meetings and external benchmarking has recently commenced.

## 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 | 49 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 100 | 0 | 0 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission included in the information pack. Access to information identifying the Code was evident throughout the facility.  On commencement of employment, staff receive induction orientation training regarding residents’ rights and their implementation. Ongoing education regarding consumer rights is held and this is part of the education calendar. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to their needs. |
| 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 | An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.  The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA) relating to residents’ rights and the sharing of information. Advance directives are encouraged and discussed at the time of admission and signed by the resident if competent to do so. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative’s care and decision making.  Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident’s right to receive, refuse and withdraw consent for care/services. Staff demonstrated good knowledge around challenging behaviours as evidenced in progress notes, care planning and observations at the time of audit. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocates whenever required.  Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. |
| 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 | There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident’s progress notes and care planning, such as visiting the local shopping centre, community and volunteer groups regularly visiting the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Forrest Hill Home and Hospital implements policies and procedures to ensure complaints processes reflect a fair complaints system. During interview residents, families/whānau and staff reported their understanding of the complaints process. Staff confirmed they document all complaints so issues are accurately reflected and followed up by the general manager.  The service documents the nature of the complaint, the dates received and the actions taken to address any complaint received. Documented complaints information is used to improve services as appropriate. Complaints information is shared at staff meetings and with the directors. This was confirmed in documents sighted.  Complaints forms are on display and available to residents and visitors in the main lounge area. The service has a suggestion box which is checked daily and complaints can be placed in this at any time.  There were no outstanding complaints at the time of audit.  One complaint was received by Waitemata District Health Board (WDHB) in July 2015 and was closed in December 2015. Another complaint, which went to the Health and Disability Commissioner in November 2015, was closed in March 2016. Corrective actions requested have been completed by the service. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admission agreement.  The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. Family/whanau and residents expressed that they were very happy with the care at the facility and provided by the staff. |
| 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 | The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admissions agreement. The residents’ files reviewed also reflected that residents received services that were specific and individual to their independence, personal privacy, dignity and respect.  The family/whanau members interviewed reported that the Code was explained to them on admission. Their relatives were treated in a manner that showed regard for the resident’s dignity, privacy and independence. At the time of the audit staff were seen to knock on residents’ doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.  The family/whanau interviewed expressed no concerns in relation to residents’ abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential challenging behaviours. This was also evidenced at the time of audit with observed interactions. |
| 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 | The clinical nurse manager, registered nurse and health care assistants interviewed reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents who affiliated with their culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture. A Maori health plan was available and evidenced as included in the admission booklet. |
| 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 | The residents’ files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. At the time of audit there were residents whom affiliated with seven different cultural backgrounds. The family/whanau interviewed reported that the staff are meeting the needs of their relatives and that their relative was treated in a manner that supported their cultural beliefs and values. This was also evidenced at the time of audit with observed interactions. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries and this was evidenced at the time of audit in observed interactions between staff and residents. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice was observed and evidenced in interviews with the clinical nurse manager, registered nurses, healthcare assistants and through care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents’ GPs, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants and allied health staff. Care guidelines are utilised as appropriate. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit four residents did not speak and/or understand very little English. Where hospital/consultant appointments were planned, the option of formal interpreters to support the residents and family were encouraged.  The family/whanau interviewed confirmed that they are kept informed of their relative’s wellbeing including any incidence adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents’ progress notes, accident/incident forms and at shift handover. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Forrest Hill Home and Hospital is privately owned. There are three family members who are directors of the company, one of which undertakes fortnightly meetings with the general manager of the facility. Forrest Hill Home and Hospital has a business plan in place which is reviewed annually by the directors with input from the general manager. It is monitored fortnightly by the directors to measure progress towards meeting set goals and key performance indicators.  The business plan identifies both strategic and workplace goals which show how services are planned, coordinated and delivered to meet residents’ needs. The organisation’s philosophy, mission statement and values are clearly documented and the general manager confirms they underpin all planning processes.  On the day of audit, the service had 15 rest home and 44 hospital level care residents, which totals 59.  The overall day to day management of the facility is overseen by a general manager who is a registered nurse and has had many years’ experience in aged care management. She has been in her current role for one year. The general manager attends ongoing clinical and management education.  The general manager is supported by a management team consisting of clinical manager (registered nurse), administration manager, household services manager, accounts manager and the food services manager. All members of the management team attend regular education related to the roles they undertaken. Accountability and responsibilities for each role was clearly described in the job descriptions sighted. |
| 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 | During a temporary absence of the general manager, the clinical manager undertakes the role with assistance from other members of the management team. The clinical manager’s role is shared among the senior nursing staff. During interview, the general manager confirmed there is always a director available by phone should any situations occur or ongoing advice is required.  Staff confirmed that there is no disruption to services when the managers are on leave. |
| 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 | Forrest Hill Home and Hospital has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety processes, infection control data collection and management, restraint and complaints management. All meetings are recorded using the same template which covers all of the key performance indicators plus equipment and supplies and general business. Information from the resident/family/whanau annual satisfaction survey is also used to improve services. Data collected for the before-mentioned items is collected, reviewed and trended against previously collected data. If an issue or deficit is found a corrective action is put in place to address the situation.  Corrective actions are overseen by the quality committee which consists of all members of the management team. These are discussed at management and staff meetings and reviews are documented to show how the actions put in place are evaluated. Staff confirmed they are informed of all required corrective actions by memo or at shift handover. The folder containing all memos was sighted in the both nursing offices. Examples sighted relate to improvements to be made in documentation management for staff files and ensuring all documentation in residents’ files is correctly signed. Both these areas gained a 100% pass when re-audited following corrective actions being implemented.  Quality improvements are undertaken to meet the requirements of the standard. However, it was suggested that the service document all quality improvements in more detail. For example, the changing of the placement of the resident table and chairs in the dining area to improve social interactions is well documented. This was evaluated during discussions with residents and family/whanau who all gave favourable feedback. The actions undertaken to improve staff knowledge related to the management of pressure injuries does not show how the improvements were evaluated. Following discussions with senior management it was agreed that moving forward they will document and evaluate all quality improvements to show more clearly the success (or otherwise) of the actions undertaken. Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management.  There is a process in place to ensure policies and procedures are reviewed at least two yearly or sooner if required to meet legislative changes. This process is evidence based and overseen by the general manager. All policies sighted are up to date and reflect good practice and meet legislative requirements. This includes showing the updated health and safety requirements and the need to report level three and above pressure injuries via section 31 of the Health and Disability Services (Safety) Act 2001.  Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed, monitored and managed via the quality committee with health and safety representative input. Each area (eg, kitchen, laundry, office, clinical) have an up to date hazard register. The service is pro-active in the identification of areas of risk and this is supported by them obtaining a tertiary level rating for the Work Safety Management Practices Programme from the Accident Compensation Corporation (ACC) in September 2016. Staff confirmed that they understood and implemented documented hazard identification 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 | Adverse event reporting, as identified in policy, is implemented by the service. The general manager confirmed their awareness of the organisation’s requirement related to statutory and or/regulatory reporting obligations including the need to report pressure injuries under section 31 of the Health and Disability Services (Safety) Act 2001. (Notifications sighted).  Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is shared at staff meetings, as confirmed in minutes sighted.  Documentation in residents’ files and the 2016 incident and accident forms reviewed identified that all issues reported had corrective actions put in place when required. The incident and accident forms are viewed and signed off by the clinical manager. If it is a serious harm incident, then the general manager undertakes the notification process required and the directors are notified immediately. It was noted that incident and accident forms are kept in a separate file. Following discussion with senior management it was agreed that they be filed in the resident’s file once follow up is complete.  Family/whānau notification is clearly shown in documentation and confirmed during families/whānau interviews.  Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. One example relates to the introduction of a staff member in the main lounge areas at all times to help prevent falls, as this was identified as an area where falls were occurring. Fall numbers sighted have decreased slightly and there have been no recorded falls in the lounge areas since the new system was put in place.  All incidents are discussed at RN meetings and staff meetings as required. Incident and accident types and numbers are included in the monthly directors’ report. |
| 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 | Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This was confirmed in the staff files reviewed. All roles have job descriptions that describe staff responsibilities and accountabilities. Staff complete an orientation programme with specific competencies for their roles. (Refer comment in criterion 1.3.12.3 regarding healthcare assistants (HCAs) medication competencies). Staff confirmed during interview that the orientation/induction process is overseen by a senior member of staff and that they felt confident to undertake their roles upon completion of orientation.  Documentation in the staff files reviewed confirmed all RNs have completed annual medication competencies, and that staff attend both onsite and off-site education related to the roles they perform.  Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and annual staff appraisals. All appraisals were up to date for the seven staff files reviewed.  The education calendar sighted for 2016 and 2017 identifies that staff are offered and undertake training and educational topics relate to aged care and health care services. Guest speakers include the Waitemata DHB gerontology nurse specialist, chemical provider educator and the pharmacist. Off-site education includes hospice education and HCA aged care educational days. Members of the management team also attend workshops and seminars specific to management related topics.  Resident and families/whānau members interviewed, identified that residents’ needs are met by the service. This is also supported in the resident satisfaction survey results sighted for 2016. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix are maintained to meet residents’ needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe and quality care.  Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents’ needs. There are at least two registered nurses on morning and afternoon shift and one registered nurse on night duty. All RNs hold current first aid certificates. Additional staff are rostered if the workload is very demanding. An example of this was sighted on the days of audit where a palliative care resident was being ‘specialed’ one on one by an extra staff member.  Resident and family/whānau members interviewed stated all their needs have been met in a timely manner.  The service has dedicated kitchen, cleaning and laundry staff seven days a week. The activities coordinators cover seven days a week. (This occurred as a result of a suggestion made in the 2016 resident/family/whanau satisfaction survey). |
| 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 and date of birth and national health index (NHI) are used as the unique identifier on all residents’ information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident’s record reviewed.  No personal or private resident information was observed to be on public display during the days of audit.  All residents’ files remain traceable and held within the required time frames which also encompasses the (Retention of Health information) Regulations 1996 Act. A discussion at the time of the audit was had with the clinical services manager and general manager around staff documenting in residents’ progress notes the specific time of entry, as currently staff are writing ‘am, pm or nocte’. |
| 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 resident admission agreement is based on the Aged Care Association agreement. The residents’ records reviewed have signed admission agreements by the resident/family or enduring power of attorney (EPOA).  Vacancies are updated daily through Eldernet and the facility has their own dedicated website. When enquiries are made by prospective residents and/or their family members in or outside of normal working hours, an enquiry form is completed and the facility will also follow-up with a phone call. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The facility uses the DHB’s processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident’s individual risk profile, individual file front page, medication profile form and allergies records, and a summary of medical notes is included. A copy of any advance directives are also included. Transfer of a resident to another facility includes notification to appropriate and required external services. Communication between the two services and with the family occurs prior to transfer and any concerns are documented. Documentation of a resident’s hospital transfer was sighted during the audit and was well completed. |
| 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 and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, a process when an error occurs, as well as definitions for ‘over the counter’ medications that may be required by residents. At the time of audit, no residents were self-administering medicines.  Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley in one of treatment rooms which are locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted and meets requirements. Facility and pharmacy controlled drug audits have been completed within the last six months. Medications that requires refrigeration are stored in a separate fridge.  The 16 medicine charts reviewed have been reviewed by the GP every three months and this is recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and ‘as required’ (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. The medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet.  There are documented competencies sighted for registered staff responsible for medicine management. The registered nurses administering medicines at the time of audit demonstrated competency related to medicine management; however health care assistants checking medication at night have not completed medication competency to support registered staff in checking of controlled medications. Annual training for registered staff is provided by the pharmacist. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed have a very good understanding of food safety management and have completed regular ongoing updated food safety training.  There is a four-week rotating menu. The menu has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian and/or speech language specialist review.  A nutritional profile is completed for each resident by the RN at the time of admission and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.  There is a kitchenette situated in the facility where residents/family can make their own hot and cold beverages and families can prepare and provided food for their family member.  All meals are cooked and served directly from the kitchen at the time of the meal and delivered to one of two dining rooms with residents having the option of trays in their rooms. Residents and families interviewed stated that there were no concerns and were appreciative of the kitchen staff whom were also able to cook and provide food that was individual to their likes and needs and/or also met their cultural requirements. |
| 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 | The clinical nurse manager interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (DSL) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and DSL service will be contacted so that alternative residential accommodation can be found.  If the resident’s needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service has implemented the electronic interRAI assessment and tools for all residents, however not all interRAI assessments are marked as complete. Five assessments remain in draft due to a registered nurse currently in training requiring sign of by the interRAI assessor before the assessments can be marked as complete. Two interRAI assessments that were completed by a registered nurse has since been discontinued by interRAI due to the registered nurse not meeting competencies, currently the clinical nurse manager is resubmitting these assessments. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and include falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.  The residents’ files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident’s family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk assessments.  The family/whanau interviewed reported their relative receives ‘above and beyond the care required’ to meet their needs. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Eight residents’ files reviewed have electronic care plans, with one of the eight resident’s electronic files reviewed in a draft copy. One of the eight files does not evidence an initial long term care plan, however the clinical nurse manager and registered nurse confirmed the care plan was completed, as changes were required to reflect the resident’s change in level of care. All other short and long term care plans were evidenced for this resident. The eight files reviewed have documented short and long term care plans that address the resident’s current abilities, concerns, routines, habits and level of independence and any changes implemented. Strategies for reducing and minimising risk while promoting quality of life and independence were sighted in the files. Also evidenced was the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The health care assistants interviewed demonstrated knowledge about the individual residents they care for.  Residents’ files reviewed included Lifestyle (activity) therapy care plans identifying the resident’s individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files reviewed showed input from registered nurse, health care assistants, lifestyle staff, medical and allied health services. The registered nurse and health care assistants interviewed reported they receive adequate information to assist with the resident’s continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication/diary book and resident’s progress notes.  The family/whanau interviewed reported they were very happy with the quality of care provided at the service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.  As observed on the day of the audit, the registered nurses and health care assistants demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident’s care plan. The residents’ files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.  The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident’s assessed needs and desired goals. The registered nurses and health care assistants interviewed reported they have input into residents’ care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident’s 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 uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The lifestyle (activities) staff adapts activities to meet the needs and choices of the resident.  The facility has three lifestyle staff, one of whom is training to be a diversional therapist. Combined, the lifestyle staff cover seven days a week from 0830 – 1630 (Monday to Saturday) and till 1430 (Sunday). The weekly activities plan/calendar sighted was developed based on the residents’ needs and interests and can be easily adapted and changed depending on the residents’ interest and reaction at the time. The lifestyle staff advertise the upcoming activities on the notice boards daily through the facility and a monthly calendar of upcoming events is available and provided to each resident. Health care assistants while supporting residents with personal cares remind and encourage residents to attend the activities. Regular activities include church services (group and individual visits) and included activities specific to men and women, regular visiting entertainment and volunteer/community groups and trips to other events occurring in the community, paper reading and games. For residents that wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The lifestyle co-ordinator whom is also registered as a physiotherapist has developed a ‘Fit in Body and Mind’ fitness programme which includes daily aerobic/band or weight exercise for the residents. The facility is also supported by a local gym instructor who visits and supports with exercise and a walking group. The registered nurses and healthcare staff interviewed state that they have access to activities to support residents after hours and on the weekends. Skype has been set up for residents of families whom live out of area and/or overseas of which two residents with support from staff utilise frequently. A monthly newsletter is also provided and includes past and upcoming event information and is resident focused.  The outside environment provides easy access to outside areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.  The residents’ files reviewed have activities and social assessments that identify the resident’s individual diversional, motivational and recreational requirements over a 24-hour period. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident’s file three monthly.  Resident meetings are held four times annually and the activities programme is discussed. Residents and staff interviewed stated that they are very happy with the activities provided and this was also evidenced in observation at the time of audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents’ files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal and this was also evidenced in progress notes.  Residents’ changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short-term care plans are documented in the residents’ progress notes. The health care assistants interviewed demonstrated good knowledge of short term care plans and reported that they are discussed at handover; this was also evidenced at time of the audit.  Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident’s condition. |
| 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 | There is one GP who visits the residents at the facility twice weekly. The GP also provides a 24 hour on call after hours’ service and is also supported by a locum as required. The RN or the GP arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident’s file and were observed. These referrals and consultations included mental health services, general medicine services, and referrals to a psychiatrist, radiology, geriatrician, podiatry, dietitian, and speech language therapist. The GP and an allied health specialist interviewed reported that referrals to requested services are well managed from the facility and no concerns were noted. |
| 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 | Policy describes safe and appropriate storage and disposal of waste substances which are implemented by Forrest Hill Home and Hospital. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.  Chemicals are stored securely. Chemicals are labelled in bottles provided by the contracted company who supplies them or are kept in their original purchase bottle. Safety data sheets were sighted for the chemicals in use. There is a chemical products reference chart on the wall in the laundry area where bulk chemicals are stored. A chemical hazard register is kept in all area where chemicals are located.  Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 16 June 2017.  There is a process in place to identify and manage maintenance. This includes planned annual maintenance and day to day reactive and planned items. Minor repairs are undertaken by the maintenance person employed and signed off when completed. Specialised areas, such as plumbing and electrical work, is undertaken by external contractors. It was noted during the audit that the bathroom door frame in a shared bathroom and one empty bedroom required some areas to be painted. The general manager stated these items are in the maintenance request book and that the painter is booked upon their return from leave and the maintenance man did not return from leave until the second day of audit. One wall heating was rusting. The maintenance request books sighted showed that these areas were logged.  Electrical safety testing occurs annually by a registered electrician. Clinical equipment is tested and calibrated by an approved provider at least annually and was last undertaken in January 2016. (The general manager has the 2017 update scheduled to occur later in January).  The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip and walking areas are kept clear of obstructions. Regular environmental audits are undertaken and corrective actions are put in place when required. Staff education includes awareness of all aspects of health and safety in the workplace.  Outdoor areas are easily accessed by all residents and there is appropriate seating and shaded areas. Resident and family/whanau use of the outdoor areas were observed on the days of audit.  Interviews with residents and families/whānau members confirmed the environment is suitable to meet their needs. |
| 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 are adequate toilet and shower facilities. Twenty-nine bedrooms have full ensuites, two bedrooms have a share toilet ensuite, and six single bedrooms have toilet ensuites. There is only one bedroom that does not have a hand basin and the room backs onto a common bathroom area with easy access to handwashing facilities. There are centrally located toilet and shower areas in each wing. Separate staff and visitor toilet facilities are available. Hot water temperatures are monitored to ensure they remain within safe limits for residential care. |
| 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 | With the exception of one bedroom which is a double room, the remaining bedrooms are single occupancy. The general manager confirmed the double bedroom is only used for couples who wish to share a room. At the time of audit, the room is single occupancy. All bedrooms are of a size which allows enough space for residents to mobilise safely with or without assistance. They are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings.  Resident and families/whānau members interviewed confirmed they are happy with their personal space. |
| 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 | Residents are provided with adequate areas to meet their relaxation, activity and dining needs. There are three lounge areas, two are downstairs and one upstairs. Dining areas are separate. The service has a furniture replacement programme to ensure common areas and furnishings are kept in a good state of repair. Easy chairs in the lounge areas have been replaced since the previous audit.  Activities are undertaken in the lounge and in the dining areas. This was observed on the days of audit.  Residents and families/whānau voiced their satisfaction with the environment. |
| 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 | The service has documented procedures in place for cleaning and laundry tasks. The laundry is very well set out and has a clean and dirty entrance. The only laundry done on site is residents’ personal clothing. All other laundry goes off site to a commercial laundry.  The correct use of chemicals for cleaning is maintained and pre-mixed chemicals are supplied by an offsite company. The cleaners have specific trollies to carry all cleaning items and they are stored in secure areas when not in use.  During interview, residents and families/whānau confirmed they are very happy with the cleaning and laundry services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plan is reviewed annually as part of the quality process. Emergency fire equipment is checked annually by an approved provider (September 2016) and there is an evacuation plan which was approved by the fire service in September 2014. There have been no changes to the facility footprint since this time. It was noted that five firefighting appliances (three extinguisher and two hose reels) did not show a current test and tag. The contracted company was contacted during the audit and this has been rectified.  Six monthly fire evacuations are undertaken with the last one occurring in November 2016. No follow up actions were required.  Emergency supplies and equipment include food and water, first aid kits, outbreak and civil defence supplies. The contents are rotated regularly so that they do not expire. Six monthly checks were sighted. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ and cooking. There is a 3000 litre water tank from which water is pumped via a generator should the main supply shut down for any reason.  The security arrangements involve staff ensuring the doors and windows are locked upon dusk. Staff carry pager phones on all shifts to ensure they can contact emergency services should they be required. Staff and residents stated they feel safe at all times. There is lock on the door between the reception area and the clinical area. This is opened by the push of button from the outside and a key code which is displayed on the wall in very large print on the inside. It releases in case of an emergency. Visitors and residents were seen using the door unassisted on both days of the audit. It is for safety reasons only. (Refer comments in criterion 2.1.1.4).  Call bells are located in all resident areas. Residents and families/whānau interviewed confirmed call bells were answered in an acceptable timeframe. The clinical manager monitors response times monthly as part of the quality processes. This is a recently commenced quality improvement following an issue identified by the complaints process. No negative comments were made by residents or family/whanau related to the call bell response time during the audit. |
| 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 resident areas have at least one opening window which provides natural light and ventilation. The facility has electric heating throughout the facility, including in resident bedrooms. There are heat pumps in resident lounge areas.  Residents confirmed that the facility is maintained at a comfortable temperature throughout the year. |
| 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 has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.  The infection control coordinator is the registered nurse. This person was not available for interview at the time of audit. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections, by using standardised definitions to identify infections, surveillance activity, noting changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.  The clinical nurse manager reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover, in short term care plans and in resident’s documented progress notes.  A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required. |
| 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 registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at staff meetings. The facility has the support of a clinical specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GP. The infection control coordinator/registered nurse is newly appointed to the role of infection control and is supported by the clinical nurse manager. The registered nurses and health care assistants interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed. |
| 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 | An infection control policy sets out the expectations the facilities uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, MRSA screening, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The registered nurses and health care assistants interviewed demonstrated good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the nurse manager. Infection control in-service education/tool box sessions are held and resident education is provided, as and when appropriate. |
| 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 | All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in meetings to reduce and minimise risk and ensure residents’ safety. The infection control nurse completes a monthly surveillance report. The service monitors respiratory tract infections, wounds, skin, ear nose and throat, urinary tract infections and gastroenteritis. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff meetings, and where appropriate, family meetings. An external contractor has recently being implemented and will be benchmarking surveillance data quarterly with other facilities. Overall monthly statistics remain low for the facility. At the time of audit no residents were identified as requiring antibiotics due to frequent infections. Short and long term care plans were evidenced to document interventions to reduce and minimise the risk of infections and regular evaluations. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policy states that restraint is only applied to enhance or maintain the safety of the resident. The use of enablers is voluntary and the least restrictive option to meet the needs of residents. Policy also covers the environmental restraint related to the door between the reception area and the clinical area. Management of this process includes ensuring that all residents and family/whanau are made aware of this prior to entry and that they fully understand how to enter and exit the facility. Residents and visitors were seen coming and going freely throughout the audit. It was confirmed during interviews that they are made aware of this process prior to entry.  At the time of audit there are five enablers and ten restraints in use. They are all bedside rails for either safety and/or to assist residents to remain as independent as possible when in bed. |
| 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 | Restraint approval occurs as part of the RN meetings as identified in meeting minutes sighted. This process is led by the restraint coordinator.  The use of restraint is discussed and approval is signed either by the resident and/or the family/whanau prior to use. This was confirmed in the review of three residents’ files reviewed specifically for restraint and enabler use. Policy described a restraint committee and the services uses the RN group as the committee.  All clinical staff interviewed voiced a clear understanding of restraint processes from gaining consent to ensuring regular monitoring is maintained. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The assessment used prior to restraint being put into place meets all aspects of this standard. The assessment is paper based and determines if restraint is required. If restraint is approved, it is then documented on the resident’s care plan as confirmed in documentation sighted. Alternative interventions are used where possible, such as using a low-low bed instead of a bedside rail. (Currently restraint is not included in the interRAI process. A discussion was held related to using the notes section to show that restraint is in use and what interventions and the frequency of monitoring required. The clinical manager confirmed they would do this going forward). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Restraint is used for safety reasons only. The only approved restraint at the time of audit is bedside rails. Alternative interventions are trialled where applicable. There have been no incidents recorded related to the use of restraint since the previous audit.  Each episode of restraint is monitored at least two hourly according to the level of risk identified. The restraint register sighted showed when restraint was first approved, the type of restraint, when it was last reviewed and the next due review date. It showed that restraint use is reviewed three monthly by the restraint coordinator as well as at the six monthly multidisciplinary review meetings which family/whanau are invited to attend. All restraint use is discussed at the monthly RN meetings. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Each episode of restraint is evaluated by ensuring staff maintain regular monitoring. This is confirmed on the monitoring forms sighted. Staff ensure the timeframe for monitoring is adhered to and the restraint coordinator undertakes audits to check all required process have been followed. No incidents or accidents have been recorded related to restraint management. Annual staff education occurs to ensure staff remain aware of how to safely manage a resident with restraint. Education is also included in the orientation package completed by newly employed clinical staff. Education includes alternatives to restraint and how to manage behavioural issues. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The trends and use of restraint is monitored monthly by the RNs to cover all required aspects of this standard. The clinical manager stated that numbers remain fairly static as many of the bedside rails in use have been requested by either the resident or the family/whanau. A discussion was held about how to better educate family/whanau about safe management of the resident without the use of restraint to try to reduce numbers. The restraint register identifies that restraint is ceased when no longer required by a resident.  The quality data collected is presented at management and staff meetings and shared with the directors each month. |

# 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 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Senior experienced healthcare assistants who work night shifts and support the registered staff by checking controlled and other medication, have not completed medication competencies. The plan for the service is to ensure health care assistants who check medications will maintain an annual competency. At the time of audit assurance was provided by the general manager that staff who checked medication would no longer do so unless they had completed a competency. The three health care assistants who work the night shift had completed medication competency the day following the audit. | Healthcare assistants do not hold competencies to support the checking of controlled and other medications on a night shift. | Ensure all staff who hold medication responsibilities are competent to perform the function they are assigned.  30 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.