

# Presbyterian Support Central - Huntleigh Home

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Huntleigh Home

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

**Dates of audit:** Start date: 1 May 2017 End date: 2 May 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:** 65

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Huntleigh Home is part of the Presbyterian Support Central organisation and provides rest home and hospital care for up to 71 residents. On the day of the audit, there were 65 residents.

The service is managed by a facility manager who is supported by a clinical nurse manager and two clinical coordinators. The residents and relatives interviewed all spoke positively about the care and support provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

The service is commended for the achievement of two continued improvement ratings for their work around reducing skin tears and the activity programme.

This audit has identified the following areas requiring improvement around staff files, care plan interventions, updating care plans and medication management.

## Consumer rights

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

All standards applicable to this service fully attained with some standards exceeded.

The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaints management process.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Some standards applicable to this service partially attained and of low risk.

Huntleigh Home continues to implement the Presbyterian Support Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented orientation programme for all roles within the service. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility manager takes primary responsibility for managing entry to the service with support from the clinical nurse manager. Comprehensive service information is available. A registered nurse completes initial assessments, including interRAI assessments. The registered nurses complete the care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Each resident has access to an individual and group activities programme. Medicines are stored appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Meals are prepared on-site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness and emergency evacuation plan. Chemicals are stored safely throughout the facility. The bedrooms are all single and each have a hand basin and some rooms have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and laundry staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. There are adequate supplies in the event of a civil defence emergency.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. During the audit, there was one resident with two restraints and three residents using five enablers at Huntleigh Home. There is a restraint coordinator for the service, who is the clinical nurse manager. Restraint minimisation, enabler use and challenging behaviour training is included in the training programme.

## Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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)
<b>Standards</b>	2	44	0	2	2	0	0
<b>Criteria</b>	2	95	0	2	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Interviews with five healthcare assistants (HCA's) (who work across each service and the am, pm and night shifts) confirmed their understanding of the Code. Interviews with six residents (two hospital and four rest home) and two family members (one hospital and one rest home) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice. Staff receive training about resident rights at orientation and as part of the in-service training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Nine resident files sampled (five rest home- including one respite and four hospital- including one residential -non aged) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. Eight of nine resident files sampled had a signed admission agreement signed on or before the day of admission and consents. One admission agreement has not yet signed and is being followed up by the service.</p>

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	A policy describes access to advocacy services. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with HCA's, residents and family members informed they were aware of advocacy and how to access an advocate.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, residents and family members confirm residents are supported and encouraged to remain involved in the community and external groups.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The service has a complaints policy in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaints' register and folder is maintained with all documentation. There were three complaints made in 2016 and three complaints received in 2017 year to date. Response to complaints is recorded and includes meetings with complainants, the recording of resolution and outcomes. Huntleigh had an on-site inspection by the MOH in late 2016 following a complaint. Actions were implemented as a result of the findings identified at the inspection audit. These were closed out on 18 January 2017 with corrective actions completed. The facility manager is responsible for complaints management and advised that both verbal and written complaints are actively managed.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client rights to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. A manager discusses the information pack with residents/relatives on admission. Residents and relatives interviewed confirmed that information had been provided to them around the Code. There is the opportunity to discuss aspects of the

		Code during the admission process. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service's philosophy results in each person's cultural needs being considered individually. Cultural needs are addressed in the care plan. At the time of the audit there were no residents that identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical nurse manager, along with the resident and family/whānau complete the documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six-monthly or annually, as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported at the Quality Committee meetings and an action plan is identified. Benchmarking reports are generated throughout the year to review performance over a 12-month period.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy. Residents and family members interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fourteen incident forms reviewed for March and April 2017 identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any changes in their family member's health status. Interviews with HCA's confirm that family are kept informed. Resident meetings occur every four months.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned,</p>	<p>FA</p>	<p>Huntleigh Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 71 residents. On the day of the audit there were 38 rest home residents and 27 hospital residents, including 2 residents on respite care and 3 residents on a non-aged (consolidated outcome agreement). All beds are dual purpose. All other residents were under the aged related residential care (ARRC).</p>

<p>coordinated, and appropriate to the needs of consumers.</p>		<p>Huntleigh Home has a 2016-2017 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior management team meeting.</p> <p>The facility manager is a registered nurse (RN) and has been in the role for the past three years with prior aged care management experience. The facility manager is supported by a clinical nurse manager. The clinical nurse manager has been in the position for 20 months. The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical nurse manager undertakes the role in the temporary absence of the facility manager and is supported by the regional manager and the PSC head office.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Presbyterian Support Central has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. The senior team meeting acts as the Quality Committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and staff meetings. A range of other meetings is held at the facility. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness. The facility manager had an understanding of the contractual agreements and requirements. The regional manager provides oversight and support to the facility manager on a monthly basis.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2016 and 2017 (year to date). Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. The service has a health and safety management system and this includes a health and safety rep who has completed health and safety level three training. Monthly reports are completed and reported to meetings and at the quarterly Health and Safety</p>

		<p>Committee meeting. Health and Safety Committee meetings include identification of hazards and accident/incident reporting and trends. A falls prevention programme is in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. A resident and relative satisfaction survey is completed annually. The 2016 surveys informed an overall satisfaction with the service for the residents at 68.42% and for the relatives at 79.31%. The 2016 surveys were completed for the first time through Survey Monkey so there was no comparison available against the prior year. A resident/relative business planning meeting was held on 24 February 2017 to discuss, identify gaps and improvements from the resident and relative satisfaction surveys. Corrective actions were implemented around: food/meals not satisfactory; lack of resident's involvement in support planning; ways to make the environment more conducive for sleeping; and no clear indication of who was who (management/staff) for new residents moving in. The corrective actions were followed up and signed off.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this can be used for comparative purposes with other similar services. Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A review of 14 incident forms identified that forms are fully completed. Follow-up assessments by a RN include neurological observations for those residents that had an unwitnessed fall or hit their head. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	PA Low	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including RNs and general practitioners (GP) and other registered health professionals are kept. Ten staff files were reviewed (one clinical nurse manager, one clinical coordinator, two RNs, four HCA's, one cook and one recreational officer). All staff files reviewed included the appropriate employment and recruitment documents including annual performance appraisals. Not all volunteers employed had completed police or reference checks, an orientation checklist and</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>agreement in place.</p> <p>The service has a comprehensive 32-week orientation programme in place. Care staff interviewed stated that they believed new staff were adequately orientated to the service. A training programme is being implemented that includes eight hours of annual education. The HCA's attend PSC training days, which cover the mandatory education requirements. Attendance is monitored. Increasing staff attendance at education was a focus for the service with good training attendance numbers for the PSC training days with over 80 staff attending the training days in early 2017 and late 2016.</p> <p>The clinical director is now supported by one full-time and two part-time nurse consultants. Each of the nurse consultants has allocated homes and portfolios, as well as teaching in the clinical and professional days.</p> <p>The Enliven PDRP programme was approved by Nursing Council in 2016 (the second aged care provider in New Zealand to have a Nursing Council approved PDRP). Two Huntleigh RNs have submitted their portfolios at competent level; these are currently being assessed, as is the senior nurse portfolio submitted by the home manager.</p> <p>The staff training plan includes regular sessions occurring as per the monthly calendar. Enliven training is guided by a training advisory group made up of the general manager, clinical director, selected managers and clinical nurse managers.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full-time, Monday through Friday. The facility manager is on call for any non-clinical matters. The clinical nurse manager and RN share the on-call duties for any clinical issues. There is at least one RN on duty 24 hours per day.</p> <p>There are 29 beds on the ground floor (hospital) and 42 beds on level 1 (rest home). There is one RN on duty in the AM, PM and night shifts on the hospital floor. There is one RN on duty in the AM and PM shifts on the rest home floor; the hospital RN on night duty covers the rest home at night.</p> <p>Advised, that extra staff can be called on for increased resident acuity. Interviews with HCA's, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>resident information is not displayed in a way that can be viewed by other residents or members of the public.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager and the clinical nurse manager. The admission agreement form in use aligns with the requirements of ARRC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Eighteen medication charts were reviewed (ten rest home- including one respite and six hospital- including one non-aged). There are policies available for safe medicine management that meet legislative requirements. Thirteen medication charts sampled met legislative prescribing requirements. Medication charts reviewed identified that the GP had reviewed all long-term resident's medication three-monthly and all allergies were noted.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>The standing orders in use comply with the Standing Orders Guidelines 2016. There were three rest home residents self-medicating on the day of audit and all required assessment, consent and review documentation had been completed.</p>

		The medication fridge temperatures are recorded regularly and these are within acceptable ranges.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Huntleigh Home are prepared and cooked on-site. There is a food services manual in place to guide staff. The food service menu was last audited by a dietitian in June 2015. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met.</p> <p>Food is transported via bain maries to the level one and level two dining areas and is then plated and served in the dining rooms. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed or are currently completing their food safety course. One cook is currently completing the IQ catering apprenticeship and the three kitchen assistants have completed or are completing NZQA qualifications.</p> <p>There are specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals.</p> <p>Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Resident feedback on the meals has resulted in an increase in the use of fresh food options and more diversified meals that appeal to a broader ethnic range. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where</p>	FA	<p>The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>

appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six-monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. Ten of ten registered nurses are interRAI trained.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	Three of nine care plans reviewed described the support required to meet the resident's goals and needs. The care plans sampled identified allied health involvement. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Registered nurses (RNs) and healthcare assistants, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse (hospice nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents. On the day of audit, there were nine wounds including one resident with a stage IV facility acquired pressure area (link hospital tracer 1.3.3). All wound documentation including assessments, care plan and evaluations were fully completed. All wounds have been reviewed in the appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service and nurse practitioners.</p> <p>Interviews with registered nurses and healthcare assistants demonstrated an understanding of the individualised needs of residents (link 1.3.5.2). There was evidence of pressure injury prevention interventions such as: two-hourly turning charts; food and fluid charts; regular monitoring of bowels; and regular (monthly or more frequently if required) weight management.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service has achieved five Eden principles and is working towards the achievement of the remaining five later this year. The service demonstrates a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. The PSC Huntleigh recreational programme (design, implementation and review) follows the Eden philosophy and is resident focused and individualised to reflect the resident wishes. The programme meets the recreational needs of the residents and reflects normal patterns of life. The programme is supported by a team of 20 volunteers. Church services are provided weekly.</p> <p>The service employs three recreational officers (one registered diversional therapist and two in training) who cover the programme seven days per week. The recreational programme is resident focused and is planned around meaningful everyday activities such as: gardening; baking; reminiscing; feeding birds; serving afternoon tea; and caring for pets. Four residents were recently provided with the opportunity of a vacation at another PSC homes. This experience was well received by all who participated in the 'vacation club'.</p> <p>There is evidence that the residents have regular input into review of the wider programme (via Eden circles resident meetings and resident surveys) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed a high level of satisfaction with the programme and confirmed that they felt listened to and had input into the development of their individual activity plan, what happens in their home and where they go on outings.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files sampled was full and reflected the interests, hobbies and uniqueness of each resident. Relatives interviewed advised that the activity programme was interesting, with lots of choice and the residents were encouraged to participate. Residents and families interviewed evidenced that the activity programme had a strong focus on maintaining independence and reducing boredom.</p> <p>In the files reviewed, the recreational plans had been reviewed six-monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that all long-term care plans were evaluated at least six-monthly and overall care plans were updated if there was a change in health status. There was at least a three-monthly review by the GP. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other</p>

<p>Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was waiting on reassessment for transfer to hospital level care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness which expires 27 November 2017. There is a maintenance person employed to address the reactive and planned maintenance programme. During the audit, two showers on level two were in the process of being refurbished. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p> <p>At PSC Huntleigh Home, care is provided across two levels. On the top floor, there are 42 resident rooms. Fifteen rooms have full ensuites and all other rooms have toilets and hand basins. On the ground floor, there are 29 rooms. Ten rooms have full ensuites and all other rooms have hand basins and toilets. There are two large communal dining areas, a recreational room, lounge areas and smaller areas for quiet activities and private meetings with family/visitors.</p> <p>The physical environment with wide corridors and spacious rooms allow easy access and movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas.</p> <p>The grounds are tidy, well maintained and able to be accessed safely. There are seating and shaded areas available. There is an internal courtyard with a water feature. The residents interviewed advised they enjoy</p>

		taking care of the internal gardens. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms are single with their own hand basins. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirm their bedrooms are spacious and they can personalise them as desired.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Huntleigh Home has a large dining area, recreational room, large and smaller lounges with seating placed appropriately to allow for group and individual activities to occur. One smaller lounge is available for reading and quieter activities and church services. Residents are observed safely moving between the communal areas with the use of their mobility aids.

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are dedicated cleaning staff that have access to a range of chemicals, cleaning equipment and protective clothing. Two of four cleaners have completed NZQA cleaning qualifications. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is completed on-site and there are dedicated laundry staff. One of two laundry assistants have completed an NZQA laundry qualification. Residents interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted. A fire evacuation drill was last completed on 28 February 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are two tanks of water for use in an emergency and also water stored in containers.</p> <p>There are adequate supplies in the event of a civil defence emergency. There are two portable petrol generators. A barbeque and portable gas cookers are available for cooking. There are emergency food supplies sufficient for three days. There are other products for at least three days such as incontinence products and personal protective equipment. There is a store of supplies necessary to manage a pandemic/outbreak. Short-term back up power for emergency lighting is in place. A minimum of one person trained in first aid is on duty 24/7. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal rooms have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated with electric ceiling heaters and maintained at a comfortable temperature. Residents and relatives interviewed confirm the environment and the bedrooms are warm and comfortable.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>PSC Huntleigh Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from all staff as the Quality Management Committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) has good external support from the PSC clinical director and PSC nurse practitioners. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and</p>	FA	<p>There are PSC infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed the level 7 CPIT course in infection control and also attends the monthly infection control forums at the DHB. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the PSC infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Infection rates are low. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there was one resident with two restraints (one lap belt and one harness) and three residents on five enablers (three bed rails and two lap belts). Staff are trained in restraint minimisation and the management of challenging behaviour.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing</p>	FA	<p>The clinical nurse manager is the restraint coordinator. Assessment and approval process for restraint use includes the restraint coordinator, RNs, resident/or representative and GP.</p>

education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whanau, in the files sampled. The restraint coordinator, the resident and/or their representative and a GP were involved in the assessment and consent process.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified through the assessment and approval processes. The files reviewed had completed assessment forms and care plans that reflected risk. Monitoring forms reviewed evidence that monitoring was occurring in the prescribed timeframes. The service has a restraint and enablers register which was up to date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at senior management/team leader meetings and at staff meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Organisational review of restraint use was evidenced to be conducted annually by the PSC resident safety group. A review of all enabler and restraint use occurs monthly at the senior management/team leader meetings and audits are completed as part of the quality monitoring programme.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. Not all volunteers employed had completed police or reference checks, an orientation checklist and agreement in place.</p> <p>There is a total of 40 HCA's (29% are currently undertaking level 2 qualification, 47% have completed level 3 qualification, 21% currently level 3 qualification and 3% have no qualification).</p>	Six volunteer files were reviewed. Six of six files did not include an agreement or reference check. One of six did not have an orientation checklist. Two of five did not have police checks and one file reviewed did not require a police check as was younger than seventeen.	<p>Ensure that all volunteers employed have police and reference checks completed and have an agreement and orientation checklist in place.</p> <p>90 days</p>

<p>Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>The GP charts the medication required for all residents on admission, on the medication chart and then reviews all medication charted at least three-monthly. One resident returned to the facility following cataract surgery and the use of the post-surgery eye drops were outlined in the resident information brochure. The administration instructions were not dated or signed by a medical officer. The eye drops were administered based on the instructions outlined in the resident brochure.</p> <p>The eye drops in use on the medication trolleys were reviewed and four of eight eye drops in use on the ground floor were expired.</p> <p>The medication chart sample size was extended to include all residents on anticoagulant therapy. There were four residents on anticoagulant therapy, which had a variable dose charted orally over a seven to thirty-day period. The variable anticoagulant therapy dose was charted on a daily basis and then bracketed and group signed by the GP.</p>	<p>i)One rest home resident (tracer) did not have eye drops prescribed correctly that had been administered.</p> <p>ii)Four of four hospital residents on anticoagulation therapy did not have the anticoagulant correctly charted.</p> <p>iii)Four of eight eye drops in use were expired.</p>	<p>i-ii) Ensure all medication is correctly charted and complies with all legal, contractual and professional guidelines.</p> <p>iii) Ensure that all medication in use is current and has not passed its expiry date.</p> <p>30 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Assessments are completed on admission, when the support plan is reviewed and with a change in health condition. The care plan is updated based on these assessments (link 1.3.8.3). Six of nine care plans sampled did not include interventions in the care plan to support all assessed care needs. The monitoring required to screen for clinical risk was included in seven of nine files.</p>	<p>(i)Six of nine files sampled (one hospital and five rest home- including one respite resident did not have interventions documented for the management of the following care needs: management of a supra-pubic catheter; high falls risk; low mood; increasing shortness of breath; diverticulitis; respiratory infection; glaucoma; aggression and agitation.</p> <p>ii) In two of nine files sampled (two rest home), the specific monitoring required for the early detection of delirium, PR bleeding and infection was not</p>	<p>i)Ensure interventions are documented to support all assessed care needs.</p> <p>ii)Ensure the care plan interventions include the type and frequency of monitoring to</p>

			documented in interventions.	manage risk.  60 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	<p>The long-term care plans are updated at least six-monthly and evidence was sighted of multidisciplinary and family input into reviews of the care plan. InterRAI and other assessments are completed following a significant change in health condition, however the care plans were not always updated following a change in care needs.</p>	<p>Three rest home files (including tracer) were not updated following a change in care need for the management of cataract surgery, acute hypertension, wandering and upper respiratory tract infections.</p>	<p>Ensure that the care plan is updated following a change in care needs.</p> <p>90 days</p>

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six-monthly or annually, as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported at the Quality Committee meeting and an action plan is identified. These were addressed in meeting minutes sighted. Benchmarking reports are generated throughout the year to review performance over a 12-month period.</p> <p>Quality action forms are utilised at</p>	<p>Huntleigh Home is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data collected, the clinical nurse manager discusses the data at the monthly staff meetings and any identified trends or issues. Any identified common themes around incidents/infections etc. results in further education and toolbox sessions. Due to the high number of resident skin tear incidents in 2015, Huntleigh Home introduced a “tearaways” project group at the end of that year, which focused on identifying strategies for the reduction of skin tears.</p> <p>Strategies included: celebrating skin tear free days by displaying the monthly calendar on the staff noticeboard; maintaining a safe environment to minimise the risk of skin tears; identifying high risk residents and taking additional precautions; and utilising limb protectors as needed. Documentation reviewed identified that strategies were regularly evaluated and the service reduced the number of skin tears by 40% during the last 6 months of 2016. The total of skin tears for the period from July to December 2016 was 33 compared to 55 in the period from January to June 2016.</p>

		<p>Huntleigh Home and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Huntleigh Home is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified.</p>	
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service has achieved five Eden principles and is working towards achieving the remaining five later this year. The service actively engages with the residents and provides them with opportunities to have a say on how the recreational programme is run.</p>	<p>The service responded to a request by the residents for more of a say in the type and range of activities that are provided. At the resident meetings, the residents identify the areas they would like to see changed or improved. This has resulted in a number of resident lead initiatives, including: the opening of a resident shop "The Trading Post" which utilises the support of a number of volunteers; the removal of the nurses' station to create a coffee and chat area for the residents; the establishment of a vacation club where the residents can have a holiday at other PSC homes; and the purchase of a resident scooter to enable residents to be more mobile in their local community. A number of students completing their Duke of Edinburgh awards are currently volunteering at the home and the residents advised they find contact with these students rather special. The residents also held a competition to design their own flag, which now hangs on the flag pole at the front door. Residents are also included on the interview panels for senior roles at Huntleigh Home and recently were involved in the selection and recruitment of a registered nurse.</p> <p>Residents report a very high level of engagement and satisfaction with how the service is run and enjoy the meaningful contribution they make.</p>

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End of the report.