# New Vista Rest Home Limited - New Vista Resthome & Hospital

## Introduction

This report records the results of a Partial Provisional Audit; 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:** New Vista Rest Home Limited

**Premises audited:** New Vista Resthome & Hospital

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

**Dates of audit:** Start date: 30 May 2017 End date: 31 May 2017

**Proposed changes to current services (if any):** An eight-bed extension with shared full ensuites has been built onto the existing facility that will increase the total number of beds available from 52 to 60.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 48

# 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

New Vista Rest Home and Hospital provides rest home and hospital level care for up to 52 residents. On the first day of audit there were 48 beds occupied (24 rest home and 24 hospital). All beds have been approved as dual-purpose beds that are able to be used for hospital or rest home level care. The facility is operated by New Vista Rest Home Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, a general practitioner and allied health professionals.

A partial provisional audit was also undertaken to establish the level of preparedness of the provider to operate a new eight bed extension to the existing building.

This audit has resulted in continuous improvement ratings relating to residents and families accessing the community, pressure injuries, a knitting group, and skin tears. There are no areas requiring improvement from this audit.

## 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. |

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

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

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

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

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

The facility manager and quality manager are responsible for the management of complaints and a complaints register was current. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous 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. |

New Vista Rest Home Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at New Vista Rest Home and Hospital and include a documented scope, direction, objectives, values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager to the owners.

New Vista Rest Home and Hospital is managed by an experienced facility manager who is an enrolled nurse and has been in this role since 2012. The facility manager is supported by a clinical nurse manager and a quality manager. The clinical nurse manager is responsible for the oversight of clinical services in the facility.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, various staff and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

There are policies and procedures on human resources management. Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on duty at all times. The clinical nurse manager and facility manager are on call after hours.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained in using an integrated electronic and hard copy files.

## 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. |  | Standards applicable to this service fully attained. |

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

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

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

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## 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. |

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

An eight-bed extension has been built with full ensuites shared between two rooms.

Single accommodation is provided with a mix of shared and single full ensuites provided. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

## 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. |

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and enablers during the audit. Appropriate documentation including a current restraint register was in place.

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

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

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 97 | 0 | 0 | 0 | 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 | New Vista Rest Home and Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training provided by the regions Aged Concern representative, as verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including consent for photographs, outings, names on doors and the collection and sharing of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements, and processes for residents unable to consent is defined and documented where relevant in the resident’s records. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. A resident’s advocate attends residents’ meetings and assists as required.  Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed with the clinical nurse manager (CNM). |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The ability for residents to maintain links with family and community has been enhanced at New Vista and this is recognised as an area of continuous improvement.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility.  The complaints register showed six complaints have been received since the previous audit. Actions taken, through to an agreed resolution, was documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.  The facility manager and the quality manager are responsible for complaints management and follow up. Staff interviewed confirmed a good understanding of the complaint process and what actions are required.  The facility manager (FM) and the quality manager (QM) reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, from discussion with staff, and discussion with the residents’ advocate when attending residents’ meetings. The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and displays of courtesy when addressing residents. All residents have a single room or share a room with their spouse.  Residents are encouraged to maintain their independence by attending community activities, arranging visits with the doctor, participation in clubs of their choosing, attendance at local social events and being enabled to maintain established lifestyle practices (refer 1.1.12). Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Staff support the two residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori model of health plan, developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Interviews reported that staff acknowledged and respect the individual cultural needs of residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed (eg, spiritual, nutritional and personal care considerations). The monthly resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their employment agreement. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through the use of evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, community dieticians, services for older people, seating specialists, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support to attend external education and access resources to support contemporary good practice.  Other examples of good practice observed during the audit include a commitment to a ‘no facility acquired pressure injury’ culture (refer 1.3.6.1) and staff providing a prompt response to residents’ request for assistance. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents, and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services are able to be accessed via the interpreter service when required. Staff knew how to do so, although reported this was rarely required due to all but one resident at present being able to speak English, staff being able to provide interpretation as and when needed, and the use of a family member for the resident for whom English is not their first language.  Staff were observed communicating effectively with residents and family. There was appropriate communication methods for the needs of all residents. Written information is available and sourced in alternative formats to suit the needs of specific residents when necessary. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | New Vista Rest Home and Hospital (New Vista) is family owned and the owners are actively involved in running the business. A business plan was reviewed that includes a mission statement, vision, purpose and objectives.  The facility manager who is an enrolled nurse (EN) has been in their current position for five years and prior to this appointment managed other aged care facilities. The management of clinical services is the responsibility of the clinical nurse manager (CNM) who has been in their role since July 2015. Prior to this the CNM was employed as a RN at New Vista. The annual practising certificates for the facility manager and clinical nurse manager are current. There was evidenced on the facility manager’s and clinical nurse manager’s files of appropriate ongoing education.  The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  New Vista occupancy on the first day of this audit was 25 rest home and 23 hospital residents. The FM advised there will be no changes to organisational management as a result of building the eight-bed extension.  The service provider has funding contracts with the district health board (DHB) to provide aged related residential care, long term support – chronic health conditions – residential, intermediate care services, carer relief and a dedicated respite bed. A contract with the Ministry of Health is also held for residential – non-aged care. |
| 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 | In the absence of the facility manager, the clinical nurse manager deputises. When the CNM is absent, a senior RN takes responsibility for clinical overview. The quality manager provides support. The FM and the CNM confirmed their responsibility and authority for these roles. The FM advised there will no changes as a result of the eight-bed extension. |
| 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 | A quality improvement and risk management plan guides the quality programme and includes goals and objectives. An internal audit programme is in place and internal audits completed for 2016 and 2017 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures.  Monthly quality meetings include RNs, ENs, health and safety, restraint and infection prevention and control. Staff meetings are held three-monthly, with a comprehensive newsletter that includes on-going education provided monthly for staff. Resident meetings include topics of interest. Meeting minutes including quality data are available in the nurses’ stations for staff to read and sign off. Meeting minutes and staff newsletters reviewed evidenced reporting of completed internal audits, quality data, including clinical indicators which are graphed. The quality manager is experienced in quality and risk management processes and is responsible for ensuring the organisation’s quality and risk management systems are maintained.  Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data included adverse event forms, internal audits, meeting minutes satisfaction surveys and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed.  Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. The ‘Lifestyle Care Plan Policy’ includes interRAI requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for the service delivery.  A Health and Safety Manual is available that includes relevant policies and procedures. Actual and potential risks are identified associated with human resource management, legislative compliance, contractual risks and clinical risk. The hazard register identifies hazards and showed the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The quality manager (QM) is the health and safety coordinator and is responsible for hazards. The QM demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.  A continuous improvement rating has been awarded for a quality initiative relating to an increase in the rate of skin tears occurring, most being a result of service delivery and the actions put in place that has reduced the rate of skin tears significantly. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff are documenting adverse, unplanned or untoward events on an accident/incident form including a complete neurological observation form and falls risk assessments completed following accidents/incidents as appropriate. These are collated by the facility manager and quality manager. The originals are kept in the residents’ files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition. The satisfaction surveys confirmed this.  Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM and QM advised there have been two essential notifications (Section 31) made to the Ministry of Health since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.  The education programme is the responsibility of the FM. In-service education is provided for staff using several ways including monthly sessions, tool box talks at handover, specific topics relating to resident’s health status, monthly staff newsletters and staff meetings. The local DHB also provides an education programme for both RNs and caregivers and staff have also attended other external education. Individual records of education including competencies are held on staff files and electronically. Attendance records are maintained. Four RNs are interRAI trained and have current competencies. The FM advised there will be no changes to the existing human resource management processes as a result of the eight new bedrooms coming on stream.  The FM advised a New Zealand Qualification Authority education programme will shortly be available for staff to complete. The FM will be the assessor for the facility and reported they are booked to complete the assessors course.  An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.  Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.  Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. An electronic programme, ‘Model of Care’ is used that is based on best practice. The FM and CSM reported they review the rosters weekly and consider dependency levels of residents and the physical environment. The minimum number of staff is provided during the night shift and consists of one RN and two caregivers. There are two RNs rostered on the morning and afternoon shifts, plus the clinical nurse manager who works morning shift Monday to Friday, inclusive.  A proposed roster was reviewed for when the eight new beds are occupied and showed the current flexible/floating hours for caregivers will become permanent to increase staff hours.  The FM and CNM are on-call after hours. Care staff interviewed reported there is adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM). They are also provided with written information about the service and the admission process. The organisation seeks updated information from NASC, GP and family/whanau for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses prescribed documentation to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, advanced directive, progress notes and care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example observed of a patient transferred to the local acute care facility showed a planned and coordinated approach. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using a manual system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. The increase in resident numbers will require no changes in the present medication management system.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as requested.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.  There are two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.  Standing orders are used, are current and comply with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in 2016. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Any complaints around meals, requires the cook to get the FM and quality manager to partake in a meal, and complete an audit. Any identified corrective actions required are addressed immediately, as was observed on the day of audit. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of overall resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Two residents expressed some dissatisfaction with the evening meal. Management was aware of this and is in the process of making changes to the food services. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.  An increase in resident numbers is able to be accommodated by the present kitchen. Additional furniture has been purchased to meet increased resident numbers at meal times. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of four trained interRAI assessors on site. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by interRAI assessments are reflected in the care plans reviewed.  Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The services commitment to ‘zero tolerance of pressure injuries’ is recognised as an area of continuous improvement. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by a qualified diversional therapist and an activities co-ordinator.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as their needs change and as part of the formal six monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include lunch outings at a local club, attendance at the communities knitting group meetings and attendance at the local monthly dances. The activities programme’s responsiveness to the request of residents to promote the opportunities for residents with an interest in knitting, is recognised as an initiative of continuous improvement.  The activities programme is discussed at the minuted residents’ meetings and indicated residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme, however a request for more interesting activities and a reinvigoration of craft type activities is at present being addressed. Residents interviewed confirmed they find the programme satisfactory.  The planned activities programme and the resources available are verified to be adequate to accommodate the increase in resident numbers. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner if they wish. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the wound care nurse, diabetic nurse specialist and the hospice. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.  There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances. The FM reported there will not be any changes to the management of waste and hazardous substances because of the eight-bed extension. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed that expires 22 June 2017. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. The entire facility is spacious and passage-ways are wide. Residents confirmed they can move freely around the facility and that the accommodation meets their needs.  An eight-bed extension has been built onto the existing facility with shared full ensuites. A certificate of public use was sighted for the extension.  There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by maintenance person. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current.  There are external areas available that are maintained to an adequate standard and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. The rooms on one side of the new extension open out onto a decking where residents will be able to sit outside their own rooms.  Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it. |
| 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 | All bedrooms have either full ensuites or shared full ensuites. There are adequate numbers of additional bathrooms and toilets throughout the facility. Residents and families reported that there are sufficient toilets and they are easy to access. The new bedrooms have shared full ensuites.  Appropriately secured and approved handrails are provided and other equipment is available to promote residents’ independence including the four new ensuites. |
| 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 | All bedrooms are spacious. There is plenty of personal space provided for residents and staff to move safely around in all the bedrooms. The eight new bedrooms have been built to the same size as the existing bedrooms. Residents and families spoke positively about their or their relative’s accommodation. Rooms are personalised with furnishings, photos and other personal adornments.  There is adequate room in the facility to store mobility aids such as mobility scooters, wheelchairs and walkers. |
| 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 | Numerous areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is washed on site. Residents and families reported the laundry is managed well and residents’ clothes are returned in a timely manner.  New Vista is cleaned to a high standard. There are dedicated cleaners on site who have received appropriate education. The cleaners and laundry person demonstrated a sound knowledge of processes. Residents and families stated the facility is always clean. The satisfaction surveys confirmed this. Chemicals are stored securely. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals. The FM advised there will be no changes to the cleaning and laundry services as a result of the extra eight beds being occupied. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A letter from the NZ Fire Service dated 30 May 2017 confirmed the fire evacuation scheme remains approved and states: “We can confirm that this addition is included in the original staged evacuation approval”. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly. The quality manager reported the next trial evacuation will be a staged evacuation which will include the new extension. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted and all equipment had been checked within required timeframes.  There is always at least one staff member on duty with a current first aid certificate.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up lighting is available should there be a power outage.  There are call bells to alert staff. The new extension has call bells in all resident areas that are connected to the existing system. Residents and families reported staff respond promptly to call bells.  Contractors must sign in and out of the facility. The external doors are locked in the early evenings. Sensor lights are situation externally and the RN on the PM and night shifts carry out internal rounds of the facility. |
| 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 | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by heat pumps and gas under floor and ducted through the ceilings including the new extension. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the Quality Manager (QM) and the organisation’s IPC nurses. The IPC programme and manual are reviewed annually.  The RN is the designated IPC nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CNM and tabled at the quality meeting. This meeting includes the FM, CNM, QM, IPC nurse, the health and safety officer, and representatives from food services and household management.  An increase in resident numbers will not require any changes to be made to the IPC programme.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC nurse has appropriate skills, knowledge and qualifications for the role, and has been in this role for two years. She has attended study days in IPC as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisor is available if additional support/information is required. The nurse has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of IPC policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the IPC annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the infection control nurse. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this and management is documented in the residents’ clinical records and on infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The IPC nurse reviews all reported infections. Monthly surveillance data is collated, recorded and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality meetings, staff meetings and at resident handovers as confirmed in meeting minutes sighted and interviews with staff.  Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the CNM, FM, quality and staff meetings. Data is benchmarked internally within the group. Benchmarking has provided assurance that infection rates in the facility are low. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service demonstrated that the use of restraint is actively minimised. There were six residents using restraint and two residents using an enabler during the audit. The restraint coordinator is the FM and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.  The restraint approval group forms part of the quality meetings. Restraint is also an agenda item at the staff meetings. Meeting minutes confirmed this. |
| 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 | A signed job description for the restraint coordinator was evident in the FM’s file and in the restraint folder. Responsibilities of the restraint coordinator and approval group are clearly outlined. Restraints to be used for the residents are approved by the restraint approval group prior to commencing the restraint, this includes the resident’s GP. The GP completes three-monthly reviews of the restraints in use.  Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessment forms, completed prior to commencing any restraint, were in the files of those residents using restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Safe use of restraint is actively promoted. There is a current and updated restraint/enabler register. The management plans include any risk factors and ensures the resident’s safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There are restraint minimisation policies and procedures that are accessible for all staff to read. There were no restraint-related injuries reported. There were monitoring forms for all residents who are using restraint and these were completed as required. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint and enabler use is evaluated at least three-monthly and the resident’s care plan six monthly. Consents and evaluation forms were signed by the GP and the resident’s family/EPOA. The evaluation form included the effectiveness of the restraint and the risk management plans documented in the long-term care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at least three-monthly. Meeting minutes confirmed this. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint approval group is responsible for monitoring and reviewing restraint. Restraint is also monitored through the internal audit programme. Identified issues are discussed in the quality and staff meetings as well as additional education that is required to support staff. This has included education relating to restraint and challenging behaviour. Staff had good knowledge relating to managing challenging behaviour. |

# 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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| No data to display |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.12.2  Consumers are supported to access services within the community when appropriate. | CI | Documentation in 2014 expressed some residents and their families desires to go out, however this was limited by the resident being in a wheelchair. Mobility taxis were often unavailable, and the use of the New Vista van was cumbersome and often not available due to facility requirements.  A special purpose vehicle was purchased, especially designed to allow access to one resident in a wheelchair. It is easily operated and can be booked by family members to enable them to attend functions and appointments. Outings are not reliant on New Vista staff presence.  The booking system and interviews evidences the high usage of this vehicle and the advantages of the initiative. In addition to regular outings residents have been enabled to attend out of town activities, anniversary’s, funerals, unveilings and numerous other events with their family and independently. There are currently six residents who are utilising this vehicle on a regular basis for a variety of reasons. | A small vehicle capable of accommodating a wheelchair has been purchased and enables individual residents and their families the opportunity to go out independently. |
| Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system. | CI | Through the analysis of accident/incident forms it was identified that there was a noticeable increase in the number of skin tears being sustained at both rest home and hospital level care. The majority of skin tears were occurring during the day and were the result of both service delivery and mobile residents knocking their arms and legs. Staff were presented with the results through the quality and staff meetings including graphs.  Specific education was provided to staff that focused on care and vigilance during manual handling, the frailty of aged skin and awareness concerning those residents who were prescribed certain medication, such as warfarin. Education and discussion was also undertaken with residents both individually and at residents’ meetings. A skin tear questionnaire was developed and staff required to complete and attach to the accident/incident reporting forms following all skin tears sustained from any staff action. The questionnaire included questions regarding the resident’s level of care; how many staff were assisting the resident at the time; whether equipment was being used correctly; were the resident’s limbs positioned correctly; was there adequate support, and how could the skin tear have been prevented. For those residents who sustained skin tears through knocking their own limbs, staff were also required to answer questions about whether residents at risk were wearing appropriate limb protectors.  Analysis following the implementation of the actions put in place and the willingness of staff to be committed to reducing the rate of skin tears has resulted in a significant reduction in the rate of skin tears, especially those staff related, during service delivery. Increasing the use of limb protectors for those residents identified as being at risk and using extra padding during transfers has proved to be beneficial in keeping the rate of skin tears low. Documentation showed skin tears have continued to decrease. In 2013, skin tears numbered 34, by the end of 2016 the rate had dropped to six for the year (a 42% reduction). Review of documentation and interview of the quality manager evidenced skin tears rates have remained low and have been sustained due to residents attempting to remain as independent as possible. | As a result of actions taken after identifying there was a significant increase in residents sustaining skin tears during service delivery and less so by mobile residents, the rate of skin tears has reduced significantly. During 2013 the rate had increased to 34; by the end of 2016 the number had reduced to six, a 42% reduction. Skin tears have remained low and are now a result of those residents attempting to remain as independent as possible. |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | CI | In late 2015 and early 2016 New Vista had three PIs. Two of those were facility acquired (one related to a shoe rubbing and one where the resident was non-compliant with management strategies) and the third resident was admitted with the PI. The facility developed an initiative around zero tolerance to facility acquired PI and a commitment to resolve PIs presenting on admission.  Staff education, training sessions and awareness is constantly encouraged, including monthly team talks at handovers and ward meetings, staff newsletters, posters and on the floor training with the emphasis being on prevention.  In 2016, there were seven pressure injuries. The three previously mentioned and four new admissions, with PIs. In 2017 one resident sustained a PI during a hospital admission. All PIs have been resolved apart from one where the resident has a chronic medical condition that compromises the circulation. New Vista has had no facility acquired PIs since early 2016. Interviews and observation verify the facilities commitment to zero tolerance of PIs. | The service has a zero tolerance to pressure injuries. Since early 2016 all pressure injuries in the facility have been acquired elsewhere. The facility has resolved all but one of those pressure injuries, through their commitment to preventative strategies. |
| 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. | CI | In 2015 four residents expressed an interest in having a knitting group at New Vista. This was started, and expanded into the community, with the van taking the ladies to the local monthly knitting group meetings. The knitting group has increased in popularity with there now being 14 residents as part of the group. The sessions increased from monthly to fortnightly and now weekly, at the request of residents. The meetings are now held at New Vista and husbands of residents often attend. The lounge is often full of residents, family members, chatter and laughing amongst the clicking of needles. On occasion ‘happy hour’ is added.  Wool is donated and sometimes purchased. The blankets made are donated to overseas aid agencies or local aid agencies that the group nominate. Residents are proud they are able to contribute in some way. Observations and interviews verify the satisfaction residents and their families get from this initiative. | The activities programme at New Vista has established a knitting guild that has improved the number of residents and community involvement in knitting and associated social activities. |

End of the report.