# Presbyterian Support Central - Longview Home

## 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](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:** Presbyterian Support Central

**Premises audited:** Longview Home

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

**Dates of audit:** Start date: 15 August 2017 End date: 16 August 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:** 50

# 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

Longview Home is part of the Presbyterian Support Central organisation and provides rest home and hospital care for up to 60 residents. On the day of the audit, there were 50 residents.

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

This audit has identified the following areas requiring improvement: complaint management, quality programme, adverse event reporting, performance reviews, implementation of care, activities, food service, and call bells.

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

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. |

Longview 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

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

The clinical nurse manager takes primary responsibility for managing entry to the service with support from the facility 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 group activities programmes and some individual. Medicines are stored appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. 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 satisfied with the food service.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

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 a shared ensuite toilet. 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 maintenance 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.

## 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. |

There is a restraint policy in place that states the organisation’s philosophy is restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were two residents with restraint and no residents using enablers. 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

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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. |

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)** |
| **Standards** | 0 | 42 | 0 | 6 | 2 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 8 | 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)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) has been incorporated into care. Interviews with three registered nurses, eight healthcare assistants (HCAs) who work across each service and the am, pm and night shifts and one diversional therapist, confirmed their understanding of the Code. Interviews with eight residents (three hospital and five rest home) and eight family members (five hospital and three 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. |
| 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 | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Seven long-term resident files sampled (four hospital and three rest home - including one close in age and interest), demonstrated that advanced directives are signed for separately. One rest home resident admitted for respite care had not completed an advanced directive. There is evidence of discussion with resident/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. Seven resident files sampled had a signed admission agreement – there was documentation from the family of the eighth resident, acknowledging the agreement was being returned to the home. All files had signed consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | 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 HCAs, residents and family members informed they were aware of advocacy and how to access an advocate. |
| 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 | 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.  Longview Home was visited last year by Eden in Oz & NZ to achieve principles 7, 8, 9 and 1 to become a fully Eden home and could demonstrate that they have created a human habitat to eliminate loneliness, helplessness and boredom. They have close and continuing contact with plants, animals and children and the Tawa community. They have introduced more animals into their home since the last audit. They now have birds, fish, cats, visiting dogs daily and canine friend visits. Continued partnerships with two local schools who both visit each fortnight and meets with their residents. Continued relationship and support from the Tawa church groups who provide church services for their residents in their chapel. Residents are part of Eden focus group facilitated by DT and are choosing names of their areas to change into more of a neighbourhood. Introduction of self service meals and breakfast buffet, wishing well, Eden sharing times with staff and residents. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The service has a complaints policy that describes the management of complaints process. There are complaint forms available. Information about complaints is provided on admission. Interview with residents and families demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint register. Not all verbal and written complaints had been documented. There were three complaints noted in 2016 and there have been four complaints 2017 YTD. The complaint documentation was reviewed. Not all complaints had been managed in align with the requirements of Right 10 of the Code. Discussions with residents and families confirmed that their issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | 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. The facility 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. |
| 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 | 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 and 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. |
| 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 | 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 was one resident that identified as Māori and the resident (interviewed) confirmed that their cultural values and beliefs were being met. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The 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. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. The service has a 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. Key issues are reported at the quality committee. Benchmarking reports are generated throughout the year to review performance against other PSC sites over a 12-month period.  Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects satisfaction with the services that are provided. Residents interviewed spoke positively about the care and support provided by the staff. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.  The PSC 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. 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). The Nursing Council assessors were particularly impressed with the quality of the competency exemplars in the portfolios presented. One Longview RN has holds a portfolio at Competent level.  For several years now, it has been Enliven practice to include at least one resident on interview panels for senior roles. One of the residents participated in the appointment of the clinical nurse manager.  The GP interviewed is satisfied with the care that is being provided by the service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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. Nine incident forms reviewed for July 2017 identified family were notified following a resident incident. Interviews with HCAs confirm that family are kept informed. Relatives interviewed confirmed they are notified of any changes in their family member’s health status. The service has just commenced an initiative, of emailing families a copy of the social calendar, menu and newsletter every Monday. Families interviewed were very complimentary of this communication. Resident meetings occur every four months. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Longview Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 60 residents. On the first day of the audit there were 50 residents. There were 33 rest home residents, including one resident admitted under a respite contract and one resident admitted under a close in age and interest contract and 17 hospital residents. All beds are dual-purpose.  Longview Home has a 2017 – 2018 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.  The facility manager is a registered nurse (RN) and has been in the role since 2003. The facility manager is supported by a clinical nurse manager and a clinical coordinator. The clinical nurse manager has been in the position since February 2017 and has previous clinical management experience. The clinical coordinator has been in the role since 2015. The facility manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| 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 | The clinical nurse manager undertakes the role in the temporary absence of the facility manager and is supported by clinical coordinator, the regional manager and the PSC head office. |
| 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. | PA Low | PSC has a documented quality and risk management programme. Interviews with the facility manager, clinical nurse manager, clinical coordinator, registered nurses and care staff reflected their understanding of the quality and risk management systems that have been put into place. The regional manager provides oversight and support to the facility manager and meets with the facility manager at least fortnightly.  PSC policies and procedures and associated implementation systems provide a good level of assurance that Longview 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 follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control at Longview; ensuring staff are kept up-to-date with the changes. Staff are requested to sign that they have read the new/revised policies.  Quality data collected is being collated, however the data has not consistently been trended and analysed and where corrective actions are required, corrective action plans are not being consistently documented and implemented. The PSC meeting schedule has not been fully implemented and Longview quality data has not regularly been communicated to staff. PSC has recently implemented benchmarking with all PSC sites, via an electronic database system and has introduced a centralised system, which monitors the due dates of assessments and support plan reviews.  The senior team meeting at Longview Home acts as the quality committee and they meet twice a month. Meeting minutes and reports from other on-site meetings held are provided to the quality meeting. Progress with the quality programme/goals has been monitored and reviewed at the senior team meetings.  A health and safety programme is in place at Longview Home that meets current legislative requirements. An interview with the facility manager and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility’s health and safety programme. The hazard register is regularly reviewed (last review May 2017). The organisation has recently employed a person to complete an organisational-wide review of the PSC health and safety management system.  Falls prevention strategies are in place on a case-by-case basis.  A number of quality improvements have been made since the last audit, including achieving all ten Eden principles, implementation of self-service meals for residents, refurbishment of all resident bedrooms with the provision of electric beds for all residents, refurbishment of the entrance foyer, communication with all families weekly, the establishment of the Whānau team and the implementation of a project to reduce skin tears.  A resident and relative satisfaction survey is completed annually. The surveys completed in December 2016, informed satisfaction with the service. |
| 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. | PA Low | 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 internal benchmarking programme.  A review of nine incident forms identified that forms are fully completed however, incident forms were not completed for all current pressure injuries. Follow-up neurological assessments by a RN did not always occur, as required by the organisational policy following an unwitnessed fall (link 1.3.6.1). Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | 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. Eight staff files were reviewed (one facility manager, one clinical nurse manager, two RNs, two HCAs, one cleaner and one cook). All staff files reviewed included the appropriate employment and recruitment documents, however not all staff files evidenced an annual performance appraisal. Six volunteer files were sampled and evidenced police or reference checks, an orientation checklist, and had signed volunteer agreements.  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 HCAs attend PSC training days, which covers the mandatory education requirements. Attendance is monitored. 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.  Five of eight registered nurses and the facility manager, clinical manager, and clinical coordinator are all interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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 and rotate shifts so that one or the other is on duty six of seven days. There is a clinical coordinator who works on a morning shift Monday to Thursday. The clinical nurse manager and clinical coordinator share the on-call.  In addition to the clinical nurse manager and clinical coordinator, there are two registered nurses (or one registered nurse and one enrolled nurse) on a morning shift. There is one registered nurse on an afternoon and one on a night shift. There are seven HCAs on an AM shift (four long and three short shifts) and six HCAs including one medication competent HCA on an afternoon shift (four long and two short shifts). There are two HCAs on the night shift. Staff interviewed advised that extra staff can be called on for increased resident requirements. Interviews with HCAs, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The 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 clinical nurse 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 clinical nurse manager and facility manager. The admission agreement form in use aligns with the requirements of ARRC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | 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. Relatives are notified if transfers occur. |
| 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 | Sixteen medication files were sampled (eight hospital and eight rest home). The service at present is using a paper-based medication management system but is moving to an electronic medication management system in a month (training has been undertaken). All medication charts reviewed included and recorded any changes to medication doses. The medication management policies and procedures comply with medication legislation and guidelines. Residents’ medicines are stored securely in the medication room/cupboard. Registered nurses, enrolled nurses and senior HCAs administer medicines. Medication rounds were observed and practices align with policy.  All staff that administer medication are competent and have received medication management training. The facility uses a robotic packed medication management system for the packaging of all tablets. The two RNs on duty reconcile the delivery and document this. There was evidence of three-monthly reviews by the GP. One resident was self-administering their own medicines. The medications were securely stored, documentation was correctly recorded and a competency assessment completed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. The cook advised that a resident nutritional profile is developed for each resident on admission. Nutritional profiles were available in the kitchen for all residents. The nutritional profile is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the RNs on duty. The head cook is assisted by two further cooks, a relieving cook and kitchenhands. All kitchen staff who handle food have completed food safety training.  The kitchen follows a rotating seasonal menu overseen by a PSC contracted dietitian. Refrigerators and freezers in the kitchen area, and cooked food temperatures are monitored and recorded, however this did not apply to additional fridges in the kitchenettes of two lounges that stored resident food. The food stored in these fridges was not covered or dated and the temperatures of the fridges were not recorded. Continental breakfast is available in a smaller lounge dining area or delivered to rooms. In the area where continental breakfast is served, residents may make their own toast and choose cereal. This is part of the recent initiative to promote resident independence and enjoyment of meals. Lunch and dinner are served in the main dining room with residents being able to self-serve, if able, from the servery. The servery had been designed and installed recently to implement self-service meals in the dining room and improving the dining room experience for residents by encouraging the residents to have more independence and choice at meal times. The servery was designed with sufficient side space to enable residents to slide their plate along. Residents who are able are enjoying being able to choose what they want to eat and the size of the meal. Some residents and the family members interviewed stated the food was bland, others expressed satisfaction. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reasons for declining service entry should this occur and communicates this decision to family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Eight files sampled indicated that all appropriate personal needs information was gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed. Assessments had been reviewed when there was a change to a resident’s health condition. Care plans sampled were developed based on these assessments. Care plans reviewed described the level of support required to meet the goals and needs identified for the resident. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all resident files sampled except for the resident on respite. InterRAI assessments had been reviewed six-monthly. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident short-term and long-term care plans reviewed described the support required to meet the resident’s goals and needs. The interRAI assessment informs the development of the resident’s care plan and input from allied health professionals was included. Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process. Staff interviewed were familiar with residents’ current needs. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) and HCAs, follow the care plan and report progress against the care plan at handovers. If external nursing or allied health advice is required, the RNs will initiate a referral. If external medical advice is required, this will be actioned by the GPs. Clinical staff have access to sufficient medical supplies (dressings and wound care products). Sufficient continence products are available and resident files include a continence assessment and management plan.  Wound management plans were fully documented for all current wounds. Wound re-assessment and rationale for when changes were made to the wound plan were fully documented in wound progress notes, with each dressing change. Dates for re-assessment by registered nurses were indicated on the wound plan and was recorded in the RN communication diary. There were seven wounds present on the day of audit (two blisters, two skin tears, one chronic wound, one ulcer, one ingrown toenail) and three pressure injuries. All wounds have been assessed and reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the DHB.  Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions documented the interventions in sufficient detail to guide the care staff, however these were not consistently followed. There were shortfalls around the monitoring of neurological state following unwitnessed falls, restraint and weight management and the provision of specific assistance with meals. There was evidence of pressure injury prevention interventions, food and fluid intake charts, behaviour monitoring, pain monitoring and regular monitoring of bowels and regular (monthly or more frequently if required) weight management requirements. |
| 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. | PA Low | One diversional therapist is employed Monday to Friday to operate the activities programme for all residents. She is assisted by two recreation assistants (working towards diversional therapy qualifications), who between them work three weekdays. The service had achieved ten Eden principles. The programme operates five days a week with some activities and a church service occurring each weekend. The programme is supported by volunteers (approximately 30), community clubs (rotary do outings twice a month) and entertainers. At time of audit the facility van was off the road and arrangements were made to borrow a van.  An activities assessment is completed on admission, in consultation with the resident/family (as appropriate), which is incorporated into the interRAI assessment process. An activities section in the resident file includes an activities assessment, life experiences and an activity care plan. The activity care plan includes activities to meet residents’ needs (physical, cognitive, creative, social, sensory, spiritual and domestic) and includes family and community interests.  Activities are generally conducted in the lounges, dining room (where the raised bowling table is), chapel or large craft room. The activities programme is combined for rest home and hospital residents who choose what they wish to attend.  Residents are free to choose to participate in the group activities programme or undertake individual activities if able. All residents can be involved in gardening and pets are welcomed as part of the home environment and the Eden Philosophy of Care. A housebound library service visits the home.  All long-term resident files sampled have an activity plan within the care plan, however the options available to some residents to satisfy their needs was limited. There was a shortfall identified in meeting individual and some group needs. The satisfaction survey and interview with families and residents at the time of audit indicated that the programme did not meet the individual needs of some of the men, the close in age and interest resident and four of eight residents sampled. The families interviewed reported their family members had reported to them they were bored with the group programme as it was very repetitious and not meeting their intellectual needs. They reported there was nothing to do in the weekends. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review (medical assessment and review of medications) by the GP. Re-assessments have been completed using interRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 | 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 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 reassessed. |
| 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 implemented policies in place to guide staff in waste management. All 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 were stored safely throughout the facility. Safety datasheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 21 March 2018. Since the previous audit resident bedrooms have been refurbished. The contracted maintenance person undertakes the reactive maintenance and works eight hours per week and as needed. Scheduled maintenance is arranged and managed through PSC head office.  All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored monthly. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms have a hand basin and share an ensuite toilet. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a spacious lounge and dining area to meet the needs of the residents. There is also a chapel (used for a number of activities) and a large craft room to allow for activities, resident relaxation and provide privacy for residents and visitors. Two wings have smaller lounge/dining areas and there is a conservatory. The facility design allows for freedom of movement for all residents including those with mobility aids. Staff assist residents to access communal living areas as required and this was observed on the day of the audit. |
| 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 | Dedicated cleaning staff are rostered on to clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.  Dedicated laundry staff completes all laundry on-site in an appropriately appointed laundry. Residents interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. 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 adequate supplies in the event of a civil defence emergency including a generator, food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.  There are call bells in the residents’ rooms, and lounge/dining room areas however residents were not consistently observed to have their call bells in close proximity. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. Temperatures in individual bedrooms can be adjusted to suit the resident. All rooms have external windows that open, allowing plenty of natural sunlight. |
| 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 | PSC Longview 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 and the 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. |
| 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 | 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 the senior team) have 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. |
| 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 | 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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 seven 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. |
| 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 | 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. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, however where the data is indicating improvements are required corrective action plans are not consistently documented and implemented (link 1.2.3.8). Outcomes and actions are discussed at senior team meetings. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 organisation’s philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort.  Two hospital residents were using restraint (one bedrails and a T belt and one a T belt). Assessments and consent for the use of restraint were completed and evaluation had occurred three-monthly with appropriate directions recorded in the care plan. There was evidence of education in the safe use of specific restraints. There were no residents using an enabler.  Staff receive regular training around restraint minimisation that begins during their induction to the service. A restraint competency questionnaire is completed by staff each year (December 2016). |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is the clinical manager. Restraint minimisation policies and procedures describe approved restraints. Restraint use is discussed at staff meetings and the monthly senior team meeting. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. The two residents’ files where restraint was being used were reviewed. Each resident using restraint had a restraint assessment completed. Family had signed informed consent for restraint use. The restraint assessment addressed risks associated with restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is maintained. The register identifies the residents that are using a restraint or an enabler. Two hospital residents were listed on the register as using restraint. The types of restraints used were bedrails and T belts.  The two restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint use was linked to the residents’ care plans. In two of two restraint files sampled, the monitoring and recording of monitoring of residents using restraints was not evident (link 1.3.6.1). Restraint policy indicates that all residents using restraint are monitored at least hourly when out of bed and at least two-hourly when in bed. Monitoring forms for the files reviewed were not evident since March 2017. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. Restraint files reviewed evidenced that three-monthly elevations had occurred. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at the senior team 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 | A review of all enablers and restraints in use occurs monthly at the senior team meeting. An annual review of the restraint minimisation programme is completed by the Resident Safety Group at an organisational level. The reviews include identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and competency assessments. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | The service has a documented complaints management policy that complies with Right 10 of the Code. The facility manager was able to describe the actions taken regarding the complaints received, however not all actions taken in relation to the complaint investigations had been documented, and not all complainants had their complaint acknowledged in within five working days, or the outcome of the complaint communicated to them. | In the seven complaint files sampled for 2016 and 2017:  i) Four of seven (three hospital, one rest home), did not document all actions taken regarding the complaint.  ii) Two of seven (one rest home and one hospital) did not evidence a written acknowledgement of the complaint within five working days.  iii) Three of seven (hospital) did not evidence that the outcome of the complaint investigation was communicated to the complainant. | Ensure that all aspects of complaint management comply with Right 10 of the Code.  90 days |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The service has a complaint register in place to record all verbal and written complaints. One verbal complaint from a hospital resident was documented via an email, and verbal complaints received from residents about another resident’s behaviour, were not documented on the complaints register. | One verbal complaint from a resident’s family member that was documented by a staff member via email and verbal complaints about another residents behaviour had not been documented on the complaint register. | Ensure that all complaints received are entered onto the complaint register.  90 days |
| Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | PSC has a meeting planner which outlines the frequency of meetings to be held on-site. Longview has complied with the PSC meeting schedule for all site meetings, expect in relation to the requirement to hold monthly general staff meetings. There have only been two general staff meetings since January 2017 and the outcome of quality indictor data has not been communicated to staff. | General staff meetings are not being held as per the meeting schedule and there is no evidence in meeting minutes that quality data, trends, and corrective actions are communicated to staff. | Ensure that general staff meetings are held in accordance with the PSC meeting planner and communicate all relevant aspects of the Longview quality management system to staff.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The service captures quality data. The quality data is not consistently analysed and trended, and where opportunities for improvement are required, corrective actions plans are not consistently documented and implemented. Areas requiring improvement included call bell response times, food service, falls, infections, and activities. | i) Corrective action plans were not consistently documented and implemented where opportunities were identified (falls, UTIs, conjunctivitis, medication errors, skin tears).  ii) The resident and relative satisfaction survey completed in December 2016 identified that residents were unhappy with the call bell response times, and the activities programme. There was no evidence that corrective actions had been put in place to address these issues. | Ensure that corrective actions plans are documented and implemented where opportunities for improvement are identified.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | The service completes accident and incident forms for untoward events, however accidents and incident forms were not completed for all current pressure injuries. A section 31 notification was completed for one stage three PI noted on the day of audit | Two of three PIs (one rest home and one hospital) had not had the PI documented on an accident and incident form. | Ensure an accident and incident form is completed for all pressure injuries.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | PSC has an education planner in place, and although the education delivered has not followed the PSC training schedule, all education topics have been covered or have been rescheduled for later in the year. Staff who administer medication have completed medication competencies. There is a minimum of one staff member available at all times with a current first aid certificate. Staff files reviewed contained evidence of sighted job descriptions, however not all staff files evidenced the completion of an annual performance review. | Four of eight staff files reviewed did not evidence completion of an annual performance review. | Ensure that all staff have a performance review completed as least annually.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Fridge and freezer temperatures in the kitchen area were recorded and action taken if not within acceptable range. Food was covered and dated in the main kitchen, but resident food in the two satellite kitchenettes was not covered or dated. | In two lounges, there were kitchenettes that contained food for residents; (i) The food was not covered or dated (ii) the fridge temperatures were not recorded. | Ensure that all food storage complies with current legislation and guidelines.  60 days |
| 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. | PA Moderate | All residents had care plans which documented directions for their care. However, shortfalls were identified around monitoring of neurological state, restraint and weight and the provision of specific assistance with meals. | (i) Neurological observations had not been undertaken according to policy, for two of three rest home level residents following an unwitnessed fall; (ii) Two of two hospital residents using a restraint had no restraint monitoring recorded since March 2017; (iii) Directions were given to weigh a resident monthly. Four months had passed with it not undertaken; (iv) A hospital resident requiring assistance with feeding was not assisted till twenty-five minutes had passed and the meal had become cold (it was not reheated). | Ensure that all directions and documented interventions are followed to contribute to meeting the consumers' assessed needs.  30 days |
| 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. | PA Low | An activity programme was offered from which residents could pick what they may like to participate in, however this did not necessarily meet the individual needs of each resident (also refer 1.2.3.8). | On interview of residents and relatives it was found that the activity programme did not consistently meet the recreational needs of individual residents and the male gender group. | Ensure that activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the individual consumer or group of consumers.  90 days |
| Criterion 1.4.7.5  An appropriate 'call system' is available to summon assistance when required. | PA Moderate | The service has a call bell system in place. On three separate occasions over the audit period, immobile residents sitting in their rooms did not have their call bells in close proximity and there was no evidence of regular checks of these residents by the staff. | On two separate occasions, residents confined to lounge chairs were noted in the lounge areas with no access to call for assistance, and on three separate occasions residents with limited mobility, or residents who were confined to a lounge chair or lying on their bed, did not have the call bell within reach. | Ensure that resident call bells are within reach.  30 days |

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

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

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

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

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End of the report.