# Te Kauwhata Retirement Trust Board

## 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 Audit (NZ) 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:** Te Kauwhata Retirement Trust Board

**Premises audited:** Aparangi Village Residential Care Unit

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

**Dates of audit:** Start date: 18 December 2014 End date: 19 December 2014

**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:** 49

# 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

Aparangi Village Residential Care Unit provided care for up to 59 residents. During the audit there were 49 residents living at the facility that included 38 residents requiring rest home level of care and 11 residents requiring hospital level care.

This certification audit was conducted against the relevant Health and Disability Standards and the services’ contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The general manager provided oversight of the village and care unit and the care unit manager provided operational management of the facility. Staffing levels were reviewed for anticipated workloads and acuity.

Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys with benchmarking occurring.

Improvements are required to the quality programme, performance appraisals, administration of medication and to chemical storage.

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

Staff demonstrated an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Residents were treated with respect and received services in a manner that considered their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and the complaints process was available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs were assessed on admission. Informed consent policy and processes were implemented by the service, meeting contractual requirements.

Staff ensured residents were informed and had choices related to the care they received.

## 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. |

The service has a documented quality and risk management system that supported the provision of clinical care and support. Policies were reviewed and quality and risk performance was reported through regular meetings. The leadership team reviewed and monitored service delivery with monthly reports provided to the board. Benchmarking was being developed as a tool to improve quality.

There were human resources policies implemented. The service had in place an orientation/induction programme that provided new staff with relevant information for safe work practice and there was an ongoing training programme.

Staff identified that staffing levels were adequate and interviews with residents and relatives demonstrated that they had adequate access to staff to support residents when needed.

Improvements are required to documenting the resolution of issues when identified, use of data to improve services and completion of performance reviews.

## 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 low risk. |

The entry criteria for the rest home and hospital were clearly documented and communicated to the potential resident, family/whanau and referring agencies. If entry to the service was to be declined, a record was maintained and the potential resident and/or their family/whānau were referred to a more appropriate service.

Residents received timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision was undertaken by suitably qualified and/or experienced staff who were competent to perform the function. The processes for assessment, planning, provision, evaluation, review, and exit was provided within time frames that safely met the needs of the resident and contractual requirements. The service was coordinated in a manner that promoted continuity in service delivery and promoted a team approach to care delivery.

The needs, outcomes, and/or goals of residents were identified through the assessment process and were documented to serve as the basis for care planning. The care plans described the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions was consistent with, and contributed to, meeting the residents' needs. The care was evaluated at least six monthly, or sooner if there was a change in the residents' needs. Where progress was different from expected, the service responded by initiating changes to the care plan or with the use of short term care plans.

Resident support for access or referral to other health and/or disability service providers was appropriately facilitated or provided to meet residents' needs. Staff identified, documented, and minimised risks associated with each residents transition, exit, discharge or transfer.

The service provided a planned activities programme. The activities were planned and provided to develop and maintain skills and interests that were meaningful to the resident. As the service was part of a retirement village and rural community, there were opportunities for the residents to maintain links with the local community.

There were processes in place for safe medicine management system. Staff responsible for medicine management were assessed competent to perform the function for each stage they manage. There are improvements required in the recording of the medicines given and the recording of a six monthly stock count of the controlled drugs.

The residents expressed high praise for the meal services. The menu was reviewed by a dietitian as suitable for the older person living in long term care.

## 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 low risk. |

All building and plant complied with legislation. There was a current building warrant of fitness. There was a reactive and preventative maintenance programme including equipment and electrical checks.

Residents rooms were of an appropriate size that allowed care to be provided and for the safe use and manoeuvring of mobility aids. Activities occur in any of the lounges and furniture was arranged that ensured residents were able to move freely and safely.

Laundry was completed on site and managers and staff monitored cleaning to ensure that the facility was cleaned to a high standard.

Essential emergency and security systems were in place with regular fire drills completed. Call bells were in place.

An improvement was required to the storage of chemicals.

## Restraint minimisation and safe practice

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

The service has clear and comprehensive policy and procedures which meet the requirements of the restraint minimisation and safe practice standard. Restraints and enablers were only used to prevent harm and promote independent mobilisation. The service implements alternatives, where possible, to minimise the use of restraints (bed rails and lap belts). Staff training and competency assessment in safe use of restraint occurred as part of the ongoing education programme.

The quality committee reviewed individual residents at least two monthly. Monitoring and review of individual restraint interventions occurred at an appropriate frequency to determine whether there was an ongoing need for the restraint methods in place.

There were established systems and practices for the assessment, approval, monitoring, evaluation and review of any the individual residents with restraint and enabler use. The service could strengthen the quality documentation by reviewing all the restraint used, identifying trends and have clear documentation on how the service was achieving their goals in reducing restraint use.

## Infection prevention and control

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

There is a managed environment, which minimises the risk of infection to residents, service providers, and visitors. The service had a clearly defined and documented infection control programme that was reviewed at least annually. There were adequate human, physical, and information resources to implement the infection control programme and meet the needs of the service. The documented policies and procedures for the prevention and control of infections reflected current accepted good practice and relevant legislative requirements. These policies and procedures were practical, safe, and suitable for the rest home and hospital level of care.

Surveillance for infection was conducted monthly with agreed objectives, priorities, and methods that have been specified in the infection control programme. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes were acted upon, evaluated, and reported to staff and management in a timely manner. The infection control committee was incorporated in the quality meetings.

## 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 | 46 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 4 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Staff received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. The last training for staff had been in February 2014. Interviews with the care unit manager, senior clinician, general manager, four of four caregivers and a registered nurse confirmed their understanding of the Code. Examples were provided on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs. The information pack provided to residents on entry included how to make a complaint, code of rights pamphlet and advocacy information. The auditors noted respectful attitudes towards residents on the day of the audit. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Residents and their families were provided with all relevant information on admission. Discussions were held regarding informed consent, choice and options regarding clinical and non-clinical services. Informed consent obtained included the following: consent for sharing of information, consent for care and treatment, indemnity and outing consent. There were advance directives documented if the resident was deemed competent. Admission agreements sighted had all been signed. Discussions with residents and relatives identified that the service actively involved them in decisions that affected their lives. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office was provided to residents and families. Written information on the role of advocacy services was also provided to complainants at the time when their complaint was being acknowledged. Resident information around advocacy services was available at the entrance to the service and in lounge areas.Staff training on the role of advocacy services was included in training on the Code – last provided for staff in February 2014.Discussion with family and residents identified that the service provided opportunities for the family/EPOA to be involved in decisions and they stated that they had been informed about advocacy services.The resident file included information on resident’s family/whanau and chosen social networks.Staff interviewed were aware of the right for advocacy and how to access and provide advocacy information to residents if needed. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings but visitors can arrange to visit after doors are locked. Families interviewed confirmed they can visit at any reasonable time and were always made to feel welcome. Family were seen coming and going freely on the days of the audit. Residents were encouraged to be involved in community activities and maintained family and friends networks. Links were also encouraged through church with some residents still engaged in community activities including attending their own church services, bowling in the adjourning facility and attendance in community activities.Residents were included in outings with family members. A focus of the service has been on making the service and environment as welcoming as possible for family and visitors.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The organisation’s complaints policy and procedures was in line with the Code and included time frames for responding to a complaint. Complaint’s forms were available at the entrance of the facility. A complaints register was in place and the register included the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint was held in the complaint’s folder. A review of a complaint indicated that the complaint was investigated promptly with the issue resolved in a timely manner. Residents and family member’s stated that they would feel comfortable complaining. There had been one complaint from the Health and Disability Commissioner in 2012 that had been fully investigated with closure for the service through a letter received in 2014.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The senior clinician, care unit manager or registered nurse discussed the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code could also be held at the residents' meeting. Residents (eight including three rest home and five at hospital level of care) and family (seven including two with family in the rest home and five in the hospital) interviewed confirmed their rights are being upheld by the service. Information regarding the Health and Disability Advocacy Service was clearly displayed in the foyer of the facility and in other withdrawal spaces.Resident right to access advocacy services was identified for residents and advocacy service leaflets were available at the entrance to the service. If necessary, staff will read and explain information to residents as stated by the caregivers and registered nurses interviewed. Information was also given to next of kin or enduring power of attorney (EPOA) to read to and discussed with the resident in private. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity and respect and quality of life. The vision was to be recognised as an astute, responsive, person centred aged care provider who continuously strived towards excellence with a focus on providing a ‘home like environment’ that enhanced the resident’s independence and choice, within their personal limitations.The service had policies and procedures that were aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs were assessed using a holistic approach. The initial and on-going assessment included gaining details of people’s beliefs and values with the registered nurses and care unit manager interviewed stating that the care plans are completed with the resident and family member (confirmed by residents and family interviewed). Staff had annual training around privacy and dignity – last provided in October 2014. Interventions to support these were identified and evaluated. Residents were addressed by their preferred name and this was documented in files reviewed. A policy was available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour.The service ensured that each resident had the right to privacy and dignity, which was recognised and respected. The residents’ own personal belongings were used to decorate their rooms and two family members particularly stated that this was important for their relative as it had made a familiar environment for them. Discussions of a private nature were held in the resident’s room and there were areas in the facility which could be used for private meetings. There were clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers reported they knocked on bedroom doors prior to entering rooms, ensured doors were shut when cares were being given and did not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirmed the residents’ privacy was respected.Staff, residents and family report that residents' are encouraged to be as independent as possible with community activities and resources seen to be accessed by residents. The service was committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff could describe the policy around abuse and neglect and all interviewed including the general practitioner stated that there was no evidence of abuse or neglect. Staff received education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation – last provided in October 2014. Resident files reviewed identified that cultural and /or spiritual values and individual preferences were identified. There were weekly church services with some residents attending community churches. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service implemented the Maori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs were acknowledged by managers and staff interviewed. Links to local kaumatua services were documented. The site and/or rooms were blessed either by chaplains or kaumatua.There were four Maori residents living at the facility during the audit and three staff members who identified as Maori. The file of one resident who identified as Maori indicated that there was an emphasis on whanau/family engagement and on providing any specific cultural interventions identified by the resident and/or whanau. Staff were aware of the importance of whanau in the delivery of care for their Maori residents.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service identified each resident’s personal needs and desires from the time of admission. This was achieved with the resident, family and/or their representative. The service was committed to ensuring that each resident remained a person, even in a state of physical or mental decline. There was a strong culture of choice with the resident determining when cares occurred. Residents and family were involved in the assessment and the care planning processes as confirmed in interviews with residents and families. Information gathered during assessment included the resident’s cultural values and beliefs. This information was used to develop a care plan and included input from the resident and their family. Staff had annual training around cultural sensitivity – last provided in February 2014.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implemented policies and processes that ensured that staff were aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Training included discussion of staff roles and behaviour. Job descriptions included responsibilities of the position, ethics, advocacy and legal issues with a job description sighted in staff files reviewed. The orientation and employee agreement provided to staff on induction included standards of conduct. Interviews with staff and managers confirmed their understanding of professional boundaries, including the boundaries of the caregiver role and responsibilities. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Policies aligned with the health and disability services standards and were reviewed annually to two yearly and as changes in legislation and evidence based practice occurred. There was a quality framework that supported an internal audit programme.There was a training programme with sessions well attended. Residents and families interviewed expressed a high level of satisfaction with the care delivered. The general practitioner also expressed a high level of satisfaction with the service.Consultation was available through the leadership team. The board had a sub group of four clinicians, the unit manager and general manager and this group was able to discuss practice and any issues that arose. The service had worked to address recommendations that had arisen from complaints and other aspects of the quality programme with a focus on the following: i) development of systems that ensured sound communication between the board, the village and the care unit, ii) implementing the model of care that was based on the premise of choice, dignity and respect and independence for residents, iii) ensuring that there was adequate equipment, iv) provision of uniforms for staff, v) a focus on clinical improvements particularly around reducing falls, vi) continuing modernisation of the building. The residents and family interviewed confirmed that the model was in practice. The service was part of a collective with other providers and this forum was used for benchmarking, tendering and discussion of best and evidence based practice.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurred. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family were informed if the resident had an incident, accident, had a change in health or a change in needs as evidenced in 20 completed accident/incident forms and through discussion with all family interviewed. Family contact was recorded in residents’ files. Family confirmed that they were invited to the multidisciplinary meetings for their family member and to the family forum held six monthly. The satisfaction survey last completed indicated that residents and family were happy with levels of communication with the service. Interpreter services were available when required from the District Health Board. There were no residents requiring the use of interpreting services. The information pack was available in large print and advised that this could be read to residents.Staff have had training around communication in May 2014.Residents signed an admission agreement on entry to the service. This provided clear information around what it paid for by the service and what was paid for by the resident. All were signed on the day of admission.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Aparangi Residential Care Unit (known as Aparangi) included a village and care unit with a leadership team including the general manager, care unit manager, administrator and senior clinician. Communication between the managers took place on a daily basis with formal fortnightly meetings documented. There was a board meeting held monthly with trustees taking a governance role. The service has a clear mission, values and goals. A business plan 2013-2015 was documented and reviewed by the board and the leadership team. The facility could provide care for up to 56 residents with 15 rooms identified as dual purpose (able to provide rest home and hospital level of care). During the audit there were 49 residents living at the facility including 39 residents requiring rest home level of care and 11 residents requiring hospital level of care. Four of the rest home residents were requiring respite services. The general manager is responsible for the overall management of the site including the village and care unit and the care unit manager provides operational manager of the care unit with support from the senior clinician. All are registered nurses with extensive experience in aged care, mental health and emergency nursing. |
| 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 leadership team relieved for each other with the senior clinician providing cover for the care unit manager and vice versa and the care unit manager providing cover for the general manager and vice versa. The team stated that in the event of any changes in the management structure, there was always good support from the board which included four clinicians. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There was a documented quality and risk management framework that was documented to guide practice. The business plan was documented and reported on through the general manager reports to the board and through discussion at the leadership team meetings. The service implemented organisational policies and procedures to support service delivery. All policies were subject to reviews as required with all policies current. Policies were linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. The service had purchased policies from an independent consultant and it was slowly changing over to these. Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, implementation of an internal audit programme with corrective action plans documented. The service graphed data with this discussed through a range of meetings including staff meetings and through the QAQI monthly meetings. The service benchmarked through two external groups with the intention being to review trends. Improvements are required to resolution of issues identified in corrective action plans and review of trends to improve quality. Meeting minutes evidenced communication with staff around all aspects of quality improvement with the following meetings held monthly: QAQI, registered nurse, domestic, activities, roster review and two weekly leadership meetings. Staff interviewed reported that they were kept informed of quality improvements and corrective action plans. Residents and family described having input into quality improvement through the annual satisfaction surveys, six monthly family forums and through three monthly resident meetings. The organisation has a risk management programme in place that included health and safety policies and procedures, documentation of hazards proactively and reactively and an organisational risk management plan reviewed by the board and leadership team. Improvements are required to documentation of resolution of issues when these are identified and to use of data to improve service delivery.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The general manager and care unit manager were aware of situations where the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. The District Health Board and HealthCERT were informed of a complaint in 2012. The service was committed to providing an environment in which all staff were able and encouraged to recognise and report errors or mistakes and were supported through the open disclosure process. Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events. Twenty incident reports had a corresponding note in the progress notes to inform staff of the incident and any incidents were discussed at handover as witnessed during the audit. There was evidence of open disclosure for each recorded event.Information gathered was regularly shared through meetings with graphs described by staff as providing a platform for discussion. |
| 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 | The registered nurses and the managers hold current annual practising certificates. Visiting practitioner’s practising certificates were on file and included the general practitioner, podiatrist and physiotherapist. Staff files included appointment documentation and there was an appraisal process in place with the general manager and care unit manager completing staff appraisals. An improvement was required to ensuring that all staff have an annual performance appraisal. First aid and CPR certificates were held in the staff files. All staff completed an orientation programme with the senior clinician facilitating an annual training plan. Staff attendance was documented on attendance registers and on an excel spreadsheet. Caregivers were paired with a senior caregiver for shifts as part of orientation and a new staff member employed described a thorough orientation process. Annual medication competencies were completed for all registered nursing staff and senior caregivers who administer medicines to residents. Staff stated that they valued the training. Education and training hours exceeded eight hours a year for all staff with registered nurses accessing training relevant to their role.  |
| 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 staffing policy was the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. Staff were replaced when on leave. There are a total of 59 staff including the leadership team, registered nurses with at least one on duty at all times, a diversional therapist, domestic staff and maintenance staff. Residents, family members, the general practitioner and staff confirmed staffing was adequate to meet the residents’ needs. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retained relevant and appropriate information to identify residents and track records. This included comprehensive information gathered, at admission, with the involvement of the family. There was sufficient detail in resident files to identify residents' on-going care history and activities. Resident files in use were appropriate to the service. There were policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information could be accessed in a timely manner.Entries were legible, dates and signed by the relevant staff member including designation. Resident files were protected from unauthorised access by being locked away in an office. Informed consent was obtained from residents/family/whanau on admission to display photographs. Individual resident files demonstrated service integration. Medication charts were in a separate folder with medication and this was appropriate to the service. |
| 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 care facility was located within a retirement village community. The care facility provides rest home and hospital level care. The service had a care enquiry book that logs enquiries for admission. The residents were required to have an assessment for the appropriate level of care. The entry criteria, assessment and entry process was clearly documented and communicated to the potential resident and family/whanau.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | When admission was required to the acute care hospital, the service utilised the DHBs transfer form/envelope. The referral process documented any risks associated with each resident’s transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. With the transfer form/envelope, the RN reported that the service also provided a copy of any other relevant information, such as medication chart. A file of a resident reviewed with a recent admission to the acute care hospital evidenced that the transfer to and from the hospital was effectively managed. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Most of the medicines are supplied by the pharmacy in a pre-packed administration system. The medicines that are not pre-packed, such as liquid medicines, were individually supplied for each resident. The medicines and pre-packed medicine sheets were checked for accuracy by the RN when they were delivered. The pre-packed medicines and the signing sheets were compared against the medicine prescription. The GP conducted a medicine reconciliation on admission to the service and when the resident had any changes made by other specialists. Safe medicine administration was observed at the time of audit (RN administrating the lunch time medicines). The medicines and medicine trolley were securely stored. The medicine fridge was monitored for temperature daily, with the sighted temperatures within medicine storage guidelines. The controlled drugs were stored in a safe. The controlled drugs were signed out by two staff at each administration and a weekly stock count was recorded in the controlled drug register. The additional six monthly controlled drug stocktake and reconciliation was not recorded (refer to 1.3.12.6). All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medicine was signed by the GP and had the enquired level of documentation to allow safe administration of the medicines. The prescriptions were legible, recorded the name, dose, route, strength and times for administration. The medicine charts recorded the regular, short course and PRN medicines for each resident. When medicines were discontinued, these were signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months. The medicine signing sheets were not fully completed (refer to 1.3.12.6). Medication competencies were sighted for all staff who assist with the medicine management, this included the RNs and some senior caregivers. The RN reported that there were no residents who self-administer medicines. The service had policies, procedures and self-administration guidelines to assess if a resident was competent to administer their own medicines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The menu was reviewed by a dietitian as suitable for the older person living in long term care. No major changes had occurred to the menu since the last dietitian review. The service had a four week rotational menu with seasonal variations. Residents were routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met. The residents reported satisfaction with the meals and fluids provided.All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and met requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates and ongoing in house education. Some maintenance was required to the chiller door, the service had a plan to address this.  |
| 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 manager reported that they had not declined entry to any potential residents who had an appropriate needs assessment. The manager reported that if entry to the service was to be declined, the referrer, potential resident and where appropriate their family/whānau would be informed of the reason for this and of other options or alternative services. The services care enquiry book had a section to record reason for declining an admission if this was to occur. The admission agreement contained information on the termination of the agreement. The admission agreement documented if the residents needs changed and the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care. The manager reported residents requiring dementia care, psychogeriatric care and some complex medical issues had to be transferred to a more appropriate facility.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service had commenced interRAI training and had commenced conducting the interRAI assessments for the residents. A mix of the electronic records and the services own assessment tools were used at the time of audit. The service used additional assessment tools for skin integrity/pressure area risk, falls risk, continence assessment and nutritional assessment. The care plans sighted reflected the assessed needs of the residents. The assessment processes sighted in the resident’s files reviewed covered the resident’s physical, psycho-social, cultural and spiritual needs. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The service has commenced the use of the interRAI assessment and use their own care plan format. The service was currently in transition to a newer format for the care plans, with a number of different versions sighted in the files reviewed. All the care plans reviewed evidenced individualised care plans that reflected the resident's individual needs. The files of the residents reviewed using tracer methodology had appropriate care plans that identified the resident's needs and care requirements for palliative care and changed medical needs. The residents’ files and care plans reviewed at the time of audit demonstrated service integration. The residents files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations.The residents and family/whanau interviewed reported that the staff had excellent knowledge and care skills. The families expressed the involvement that the care facility and residents had in the local community was a ‘real strength’ of the service. The GP interviewed expressed satisfaction with the care provided.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The provision of services and interventions were consistent with, and contributed to, meeting the residents' assessed needs, and desired outcomes. The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. The care was flexible and focused on promoting quality of life for the residents. The resident and family of the hospital resident reviewed using tracer methodology reported ‘great appreciation’ for the individualised care that they received. All other residents and family/whanau interviewed reported satisfaction with the care and service delivery.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The residents were included in meaningful activities at the care facility and as part of the wider retirement village community. Feedback was sought from residents at the residents meeting and during activities. The diversional therapist reported that they gauge the response of residents during activities and modified the programme related to resident’s response and interests. The diversional therapist reported the activities were modified according to the capability and cognitive abilities of the residents. The activities programme covered physical, social, recreational and emotional needs of the residents. There were diversional therapy, activities, social and cultural assessments sighted in the residents’ files reviewed. The diversional therapist used the assessments to develop an activities programme that was meaningful to the residents. The diversional therapist reported that since they have only been in the role for three weeks, they were building a rapport with the residents to find out other interests and history of the residents, to include them in individual or group activities at the service. As well as the retirement village recreational resources, the service had links with other community organisations, churches and local schools.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluations were documented, resident-focused, indicated the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. The service was transitioning to a new format for evaluation of care, which was on a separate sheet, whereas there previous evaluations were recorded as part of the care plan. All the care plans sighted were developed, reviewed and evaluated at least six monthly. Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed. There was a white board in the nurse’s office that documented when a resident was on a short term care plan. It was noted that in one resident file, there was significant weight loss recorded in one month, the file did not record any action related to this change (this was not reflective of a systemic issue). The RN reported that the weight loss was an intended result of appropriate treatment of a medical condition. The residents and family/whanau interviewed reported high satisfaction with the care provided at the service. |
| 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 has one main GP, though residents were able to maintain their own GP if available. The RN or the GP arranged for any referral to specialist medical services when it was necessary. The residents files reviewed had appropriate referrals to other health and diagnostic services. Referrals were sighted for consultations with general medicine, dermatology, neurology, surgery, mental health, and radiology and cardiologist services. The GP interviewed reported that appropriate referrals to other health and disability services were well managed at the service. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances were in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and were free from damage. Material Safety Data sheets were available throughout the facility and accessible for staff. The hazard register was current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances. The provision and availability of protective clothing and equipment that was appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing was provided and used by staff. During a tour of the facility protective clothing and equipment were observed in all high-risk areas.  |
| 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 was posted in a visible location at the entrance to the facility (expiry date 22 April 2015). There had been no building modifications since the last audit. There was a planned maintenance schedule implemented. Equipment was available to meet resident needs with a test and tag programme that was up to date. Calibration of medical equipment was completed annually with the external providing confirming that they had appropriate equipment. Interviews with staff confirmed there was adequate equipment.There were quiet areas throughout the facility for resident and visitors to meet and there were areas that provide privacy when required.There were safe outside areas that were easy for residents and family members to access and small deck areas off bedrooms for residents to individualise. The service was continuing to implement a programme to upgrade and renovate older areas of the building. |

|  |  |  |
| --- | --- | --- |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There were adequate numbers of accessible toilets/bathing facilities. This included ensuite with a basin and toilet. Serviced apartments (seven) and studio rooms (nine) had full ensuites including showers. Communal toilets were conveniently located close to communal areas with a system that indicated if it was engaged or vacant. Appropriately secured and approved handrails were provided in the toilet/shower/bathing areas, and other equipment/accessories was made available to promote resident independence. Residents and family members interviewed reported that there were sufficient toilets and showers. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists and at least two staff and the resident. Rooms could be personalized with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.There was sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has lounge/dining areas including a smaller area that allowed people who required more privacy to access this. Lounge areas were large enough to hold activities with appropriate floor coverings. All areas were easily accessed by residents and staff. Furniture was appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.There was a specific area for the hairdresser and a sports area. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | PA Low | There are two laundry rooms on site with the laundry staff able to describe a clean and dirty area. Residents and family members stated that the laundry was well managed. There are cleaners on site during the day seven days a week. Cleaning was monitored through the internal audit process with no issues identified in audits. Chemicals and cleaning cupboards were able to be locked. An improvement was required to safe and secure storage of chemicals.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan was confirmed as being approved by the New Zealand Fire Service on 25 November 2011. There had been no building reconfigurations since this date. An evacuation policy on emergency and security situations was in place. A fire drill took place six-monthly with the last drill conducted in November 2014. The orientation programme included fire and security training. Staff confirmed their awareness of emergency procedures. There was always one staff member at least with a first aid certificate on duty – confirmed through review of the roster.All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. A civil defence plan was in place. There were adequate supplies in the event of a civil defence emergency including food, water, blankets and alternative cooking arrangements. An electronic call bell system was in place with residents confirming that staff were prompt in answering these. There were call bells in all residents’ rooms, residents’ toilets, and communal areas including the hallways, dining room and lounge areas.The doors were locked in the evening. Systems were in place to ensure the facility was secure and safe for the residents and staff. External lighting was adequate for safety and security.  |
| 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 were procedures to ensure the service was responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents were provided with adequate natural light, safe ventilation, and an environment that was maintained at a safe and comfortable temperature. There was a designated external smoking area.Family and residents interviewed confirmed the facilities were maintained at an appropriate temperature with radiators in all areas. The two coal fired boilers were checked monthly. The service received confirmation on the 19 December 2014 that the boilers ‘had been serviced, all automatic controls checked and were safe to operate’.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The manager (RN) has the interim role of infection prevention and control coordinator, and had taken on this role in the past two months. The previous infection control coordinator was still at the service and acted as an additional resource person for infection control. The job description for the infection control coordinator role was clearly defined. There were clear lines of accountability for infection control matters in the service through the quality meetings, and relevant information was provided to the board. The quality meeting was incorporated into the infection control committee, which had representatives from management, care staff, education, kitchen, activities, household, health and safety, and maintenance. The annual review of the infection control programme was conducted in the past 12 months. The review included the analysis for the past 12 months, education, actions implemented and review of the process for the domestic, kitchen and care services. The service had recently implemented a new format for the review of the infection control programme, with this scheduled for January 2015. The service had clear policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they did not come to work if they were unwell. There was a notice in the staff room about different infections, signs and symptoms and exclusion periods from the workplace. Notices were placed at entrances at times of the year when there was an increased risk of infections to ask visitors not to visit if they are unwell, or had been exposed to others who are unwell. The infection control coordinator reported that residents were asked to stay in their room if they have an infection risk. There was sanitising hand gel throughout the service for residents, visitors and staff.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The previous infection control coordinator attended ongoing education. The manager/infection control coordinator demonstrated current knowledge of infection prevention and control best practice. The manager was acting in the role of infection control coordinator and when a new infection control coordinator was appointed it was recommended that this person receive ongoing education in infection prevention and control. The infection control coordinator reported they can access external advice from the previous infection control coordinator, the GP, product supplier, DHB and Ministry of Health services as required. Infection control was discussed at the quality meeting. |
| Standard 3.3: Policies and proceduresDocumented 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 service used policies and procedures that were developed by a specialist infection prevention and control advisory service. The sighted policies and procedures were referenced to current accepted good practice. The infection control coordinator demonstrated sound knowledge on infection prevention and control. As observed at the time of audit staff demonstrated good infection prevention and control practices. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided by the previous infection control coordinator and external specialists. This infection control coordinator maintained their knowledge of current practice. The in-service programme contained education and attendance sheets for infection preventions and control education session. These sessions were referenced to current accepted good practice. Informal education was provided as required. The infection control coordinator gave examples of encouraging residents with fluids and personal hygiene for a resident who was experiencing recurring urine infections.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The service conducted monthly surveillance for infections. The service used standardised definitions of infections that are appropriate to the long term care setting. The infection and surveillance data for September 2014 recorded an increase in urinary tract infections. The analysis report showed that one resident was treated on three occasions in that month for a urine infection. The staff meeting minutes recorded the actions implemented to reduce the infections, which included further staff and resident education, increase in fluids, hand hygiene and informal education with the resident. The number of urine infections was reduced to one infection the following month.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint minimisation policy contained definitions that are congruent with this standard, with enablers being voluntary and the least restrictive option. Enablers were subject to the same reviews and checks as restraints. The approved restraints authorised for use were bed rails and lap belts. There were five residents with bed rails or lap belt as restraints and seven residents with bed rails as enablers. The service implemented alternative devices to reduce the level are restraint use. These included low/low bed, senior cushion, bed sensor mats, floor mats and sensor pads. The file of one resident indicated that the service was able to remove their bed rail and lap belt, through the use of alternative devices, and the resident has not had an increase in falls. There was ongoing education on restraint minimisation and safe practice. The clinical staff interviewed demonstrated good knowledge on the use of restraints and enablers.  |
| Standard 2.2.1: Restraint approval and processesServices 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 policy clearly outlined the restraint approval process and lines of accountability. The manager was the restraint co-ordinator. The restraint committee was included in the second monthly quality committee. The residents with restraint were reviewed at the second monthly multi-disciplinary team meeting, this included input from the GP. Before restraint was approved, the resident was assessed and consent was gained from the resident’s family/whanau, RN, restraint coordinator and GP. The restraint approval process included communication to the staff and board meetings.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Detailed restraint assessment and consent forms were completed for each restraint use. The assessment clearly stated the type of restraint approved, the risks relating to the use of the restraint and referred to underlying issues causing the need for restraint, for example, falls assessment ratings, any cultural needs, the purpose of the restraint and alternative strategies that could be used. The care staff demonstrated knowledge and understanding that consent forms and assessments were always completed before restraint was used. The residents who had restraint use had a consent in their file.  |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | There was evidence that restraint was only applied as a last resort. The need for this was fully assessed after consideration of alternatives and identification of risks associated with the proposed restraint. The interventions were monitored and reviewed to ensure it was clinically indicated, safe, the most appropriate option, and was discontinued when no longer necessary. There was evidence that a variety of alternative strategies have and continued to be tried with the resident who has a bed rail (review of resident records and staff interview). The resident's physical, psychological and cultural issues were taken into account during restraint assessment and use. An up-to-date restraint register was kept. All restraint use was monitored and records were kept when interventions were in use (review of monitoring records). The service reviewed the need for on-going restraint daily when first implemented, then at least every two months (through a multi-disciplinary review).  |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | Each restraint intervention was evaluated at least every two months (interview with restraint co-ordinator and review of resident records). The restraint evaluation documentation sighted included relevant aspects of this criterion. The frequency of evaluation was dependent on the level of risk associated with the restraint intervention in use (confirmed by review of resident records, review of restraint committee meeting minutes and interview with manager and the RN restraint coordinator). |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | There were meetings every two months by the restraint committee where each resident who had a restraint intervention was considered and all other matters related to restraint were considered. There was evidence these meetings reviewed the number and types of restraints and enablers in use. The monthly report to the board also recorded the numbers of restraints and enablers used. The quality assurance audit tool recorded if the restraint process was followed for the residents and if there were any over-riding concerns that needed to be addressed. There was no overall review of the extent of restraint use, trend analysis and the organisations progress in reducing restraint. A general improvement was required in the review and trending of quality data, this corrective action was made at 1.2.3.6. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, implementation of an internal audit programme with corrective action plans documented. The service benchmarked through two external groups with the intention being to review trends. The benchmarking was newly implemented.  | Not all corrective action plans showed resolution of issues. Ii) There was little evidence of the use of the benchmarking data and trend analysis to improve quality including use of information around restraints used. | Ensure that corrective action plans show resolution of issues. Ii) Use benchmarking data and review of trends to improve quality.180 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Staff files included an annual appraisal process for five of the eight staff reviewed. | Not all staff had a current annual performance appraisal.  | Complete annual performance appraisals for all staff. 180 days |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Eight of the fourteen medicine signing sheets were fully completed and had an initial for each medicine administration. In four medicine signing sheets there was one time of the day (for example lunch or breakfast) where it was not recorded if the medicine was given, or if not given, the reason why. For one of the times, the resident was away on leave, though this was not recorded on the medicine signing sheet. The RN reported that the medicines had been given. There was an area for improvement in the documentation to ensure all medicines are signed for. The controlled drugs were signed out at each administration by two staff members. The current balance of the controlled drugs stock was counted at each administration. A weekly stock count was recorded in the controlled drug register. The controlled drugs counted at the time of audit, correlated to the count in the controlled drug register. The service was required to conduct an additional six monthly stock count and reconciliation. This was not evidenced and was an area of required improvement. This was a low risk as it was related to documentation.  | Not all medicines that were given had been signed for. There was no record of the six monthly stocktake and reconciliation of the controlled drugs.  | Ensure that all medications that are given are signed for, and the reason for not giving was recorded on the medicine signing sheet. Document the six monthly stock take and reconciliation of the controlled drugs in the controlled drug register. 180 days |
| Criterion 1.4.6.3Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | PA Low | There were secure areas available to store chemicals. The group of serviced apartments was at the end of a hallway with cupboards opening into the hallway available to store household products such as cleaning equipment.  | Not all chemicals were stored in locked cupboards on the day of the audit and some residents in the serviced apartments had a cupboard in the hallway where they stored household products.  | Work with residents in the serviced apartments to find ways to store household products safely and provide training to staff to ensure that chemicals are stored in locked cupboards when the staff member was not present. 90 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.

|  |
| --- |
| No data to display |

End of the report.