# The Hillview Trust Incorporated

## Introduction

This report records the results of a Surveillance 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:** The Hillview Trust Incorporated

**Premises audited:** Hillview Rest Home

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

**Dates of audit:** Start date: 20 April 2015 End date: 21 April 2015

**Proposed changes to current services (if any):** The facility manager advised the facility is known as Hillview Home and Hospital.

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

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Hillview Home and Hospital provides hospital and rest home level care for up to 52 residents. On day one of the audit there were 48 residents. The service is managed by a facility manager. The residents and relatives interviewed were satisfied with the care provided.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, family, management, general practitioners and staff.

The service has addressed two of the five shortfalls from the previous audit relating to completion of staff education and completion of restraint monitoring documentation. Improvements are still required to completion of staff appraisals and evaluation of resident care plans.

There are new areas identified requiring improvements during this audit. The improvements required relate to timeliness of notification of the recent gastro-enteritis outbreak to the Medical Officer of Health; management of resident documentation including completion of care plans for residents on admission to the facility and use of short term care plans; medication management including staff practises, review of medications prescribed to residents and aspects of medication documentation; and aspects of food service management.

## Consumer rights

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was accessible and is brought to the attention of residents’ (if able) and their families on admission to the facility. Residents and family members interviewed confirmed their rights were met during service delivery, staff were respectful of their needs and communication was appropriate.

The general manager is responsible for management of complaints and a complaints register was maintained.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The Hillview Trust Incorporated is the governing body and is responsible for the services provided at Hillview Home and Hospital. Planning documents reviewed included a business plan, a mission statement, values, and philosophy.

The general manager is appropriately qualified and experienced and is supported by a clinical manager, who is a registered nurse. The clinical manager is responsible for oversight of clinical care. Registered nurse cover is provided 24 hours a day.

A quality and risk co-ordinator is employed for three days a week to oversee the quality programme. There was evidence that quality improvement data has been collected, collated, analysed and reported. There is an internal audit programme in place. There was evidence that corrective action plans are developed, implemented and monitored to address any shortfalls identified.

Risks have been identified and there was a hazard register in place. Adverse events are documented on accident/incident forms. There has been a recent gastro-enteritis outbreak at the facility. There was a delay in notifying the appropriate regulatory authority about this outbreak. Improvements are required to this aspect of service delivery.

There are policies and procedures on human resources management. Staff records reviewed provided evidence human resources processes have been followed. Although improvement has been made with the shortfall identified during the last audit relating to completion of staff appraisals, improvements are still required.

The validation of current annual practising certificates for health professionals who required them to practice has occurred. An educator is employed to oversee the staff in-service education programme. The educator is also the on-site assessor for the New Zealand Qualifications Authority approved aged care education programme. Improvements were noted with the in-service education records held for each staff member. In-service education has been provided and attendance records maintained.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is one registered nurse and two care givers. The clinical manager is on-call after hours. Care staff and residents interviewed reported there is adequate staff available.

## Continuum of service delivery

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

Residents receive appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified and/or experienced staff who are competent to perform the function. The service was coordinated in a manner that promoted continuity in service delivery and promoted a team approach to care delivery.

Improvements are required with some aspects of resident care planning on admission. Areas have also been identified as requiring improvement with evaluation of resident care plans.

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 supports and/or interventions to achieve the desired outcomes. The provision of services and interventions were 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. Shortfalls requiring improvement were identified with the use of short term care plans.

The service provides a planned activities programme to maintain skills and interests that are meaningful to residents.

Improvements were noted with the aspects of medication documentation that were identified during the last audit. However, additional shortfalls

with some aspects of medicine management were identified during this audit. Staff responsible for medicine management were assessed as competent to perform the function for each stage they manage.

The residents and family were satisfied with the meal services provided. The menu was reviewed by a dietitian as suitable for the older person living in long term care. Some aspects of food service management were identified as requiring improvement.

## Safe and appropriate environment

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

There have been no alterations to the building since the last audit. Documentation reviewed and observations confirmed appropriate systems are in place to ensure the residents’ physical environment is safe and facilities are fit for their purpose. A current building warrant of fitness was displayed. External areas are available for sitting and shading is provided. An appropriate call bell system is available and security systems are in place.

Residents and family members report staff respond to call bells in a timely manner. They report the response time has improved lately.

## 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. |

Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrated restraints and enablers that were least restrictive. There were residents using restraints and enablers.

Staff were not consistently signing off the documentation to indicate monitoring of residents using restraints during the last audit. Improvements were noted and this is no longer a shortfall in service delivery. Systems were in place to ensure assessment of residents is undertaken prior to enabler or restraint use being implemented. The residents’ files demonstrated enabler and restraint assessments, risk assessments and monitoring processes were implemented and followed. The restraint register was current.

## 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. |

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 is incorporated into the health and safety 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 | 13 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 42 | 0 | 1 | 6 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The general manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register was maintained that included verbal and written complaints and was reviewed during this audit.  The general manager advised there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. The general manager advised a staff member from the Ministry Of Health phoned them within the last few days to advise them the Ministry has received a complaint about the standard of care. This audit included a review of the aspects of the Health and Disability Standards identified by the Ministry.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings. This was confirmed during interview with residents and family, review of resident meeting minutes and satisfaction survey completed in November 2014.  Observations provided evidence that the complaint process was readily accessible and/or displayed. Review of quality meeting minutes and the general manager’s monthly reports provided evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirmed this information was reported to them via their meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the GP and family following adverse events which was recorded on the accident/incident forms, on family communication sheets and in the individual resident's files.  Residents and family interviewed confirmed that staff communicate well with them. Residents interviewed confirmed that they are aware of the staff that are responsible for their care. Review of the resident/relative satisfaction survey completed in November 2014 indicated most of the respondents were either ‘satisfied’ or ‘very satisfied’ with communication.  The general manager advised access to interpreter services is available via the district health board or members of the local community, if required. They also advised there were currently no residents who required interpreter services.  The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements were reviewed and this was clearly communicated in each agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Hillview Trust Incorporated is the governing body and is responsible for the service provided at Hillview Home and Hospital. A strategic and business plan was reviewed and included goals. Also reviewed were vision and mission statements, philosophy and scope of service provided at Hillview Home and Hospital. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  The general manager (GM) is responsible for the overall management of the facility. The GM, who was appointed to their current position in July 2012, is a registered nurse. The GM is supported by a clinical manager (CM). The CNM, who is a registered nurse, who was appointed in 2013 and is responsible for oversight of clinical care. The annual practising certificates for the GM and CM were reviewed and are current. There was evidence on the GM’s and CNM’s files of ongoing education.  The GM and CM provide monthly reports to the board of directors. A selection of these reports and board meeting minutes were reviewed during this audit.  Hillview Home and Hospital is currently certified to provide 18 hospital and 34 rest home level beds. The 18 hospital level beds are able to be used for either hospital or rest home level residents. There were 11 hospital and 37 rest home level residents on day one of this audit.  The service provider has funding contracts with the District Health Board (DHB) and Ministry of Health to provide aged related residential care (rest home and hospital), residential respite, and residential – non aged services. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A business plan and quality improvement plan were reviewed. Documented values, mission statement and philosophy were reviewed. These are used to guide the quality programme and include goals and objectives. A quality and risk co-ordinator is employed for three days a week to oversee the quality programme.  The service implements organisational policies and procedures to support service delivery. Policies are subject to reviews as required and policies current. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were readily available to staff in hard copy.  Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There is documented evidence that quality improvement data is collected, collated and analysed.  Meeting minutes evidenced communication with staff relating to quality improvement and risk management. Meetings included two weekly registered and enrolled nurse meetings, weekly operational meetings, monthly staff meetings, monthly health and safety/infection control/quality meetings and monthly resident meetings. Staff, residents and family reported that they were kept informed of quality improvements.  There was an annual family and resident satisfaction survey with the majority of the respondents reporting they were either ‘satisfied’ or ‘very satisfied’ with the service provided.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard is identified. Hazards were addressed or risks minimised or isolated.  Chemical safety data sheets were available that identify the potential risks for each area of 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 | Staff were documenting adverse, unplanned or untoward events on an accident/incident form. Neurological observations and falls risk assessments are completed as appropriate.  Registered nurses (RN) are advised of all adverse events and undertake an assessment of the resident. The RN is responsible for investigating the event as well as for documenting any corrective actions required and notifying the family. All accident and incident forms are reviewed by the clinical manager (CM) and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident form.  Resident files reviewed provided documented evidence of communication with family and GP on the accident/incident form, in resident progress notes, and in whanau/family communication sheets. There was also evidence of notification to family of any change in the resident’s condition. This finding was confirmed during interviews of residents and family members. There is an open disclosure policy.  Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control). However, improvements are required with staff awareness of the need to notify the appropriate statutory authorities in a timely manner (see criterion 1.2.4.2). |
| 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 | Criteria 1.2.7.3 and 1.2.7.5 were identified as requiring improvement during the last audit. Improvements have been made to criterion 1.2.7.5 but improvements are still required with criterion 1.2.7.3. There is at least one staff member with a current first aid certificate on each shift.  Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates were reviewed for all staff that require them to practice and were current.  A registered nurse is employed for 12 hours a week to oversee the in-service education programme and support staff to complete the New Zealand Qualifications Authority approved aged care education modules. There was evidence available indicating in-service education was provided for staff at least three times each month. An education calendar was reviewed. Improvements with the management of staff education records was observed. Individual staff attendance records and attendance records for each education session were reviewed and provided evidence ongoing education was provided. Staff are also supported to complete education via external education providers. Competency assessment questionnaires were available and completed competencies were reviewed.  Improvements have been made since the last audit with the completion of staff performance appraisals and most staff now have current performance appraisals. However, improvements are still required as documentation indicates there are still some staff without current performance appraisals (see criterion 1.2.7.3)  An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The registered nurse educator  advised that staff were orientated for various lengths of time at the beginning of their orientation. They also advised staff are extranumery for between two and six weeks at the commencement of their employment. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.  Care staff interviewed confirmed they have completed an orientation, including competency assessments (as appropriate). |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day. On call after hours registered nurse support and advice is provided by the clinical manager. The minimum amount of staff on duty is during the night and consists of one registered nurse and two caregivers. Observations during this audit confirmed adequate staff cover is provided.  Care staff interviewed reported there is adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift.  Residents and family interviewed reported staff provide them with adequate care. This finding is confirmed during review of the November 2014 resident/relative satisfaction survey. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The shortfall identified with medication documentation during the last audit has been addressed. However, additional improvements relating to medication documentation and safe staff practise have been identified during this audit (see criteria 1.3.12.1 and 1.3.12.6)  The clinical manager and registered nurses reported that prescribed medications were delivered to the facility and checked on entry. The medication areas, including controlled drug storage areas were appropriate and secure, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register was maintained. Registered nurses completed weekly checks and six monthly physical stock takes were completed by the pharmacists. Medication fridge temperatures were recorded and were within the recommended range.  Staff members authorised to administer medicines have current competencies. The lunchtime medication round was observed on both days of the audit. Improvements are required as a staff member was observed leaving the medication trolley unsighted and unattended during the lunchtime and evening meal medication round on day one of the audit (see criterion 1.3.12.1).  The staff interviews confirmed staff members were knowledgeable about the medicine administered and sign off. Administration records were maintained, as were specimen signatures. Staff education in medicine management has been provided.  Improvements are required with three monthly medicine reviews (see criterion 1.3.12.6). Discontinued medicines were not consistently dated and signed by the GPs (see criterion 1.3.12.6).  There were no residents who self-administer medicines. There is a policy on self-administration of medication by competent residents.  Most of the medicines were supplied by the pharmacy in a pre-packed administration system. The medicines that were not pre-packed, such as liquid medicines, were individually supplied for each resident. |
| 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 | 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 menu is currently being reviewed. The service has a three week rotational menu with seasonal variations. Residents were routinely weighed at least monthly, and more frequently when indicated. Additional supplements were offered to residents who were under-weight. Residents with additional or modified nutritional needs or specific diets had these needs met. The residents reported satisfaction with the meals and fluids provided. They also reported they are satisfied with the size of the meals, variety and choices and there is enough staff to assist at meal times.  The kitchen is fully equipped and staffed to meet the needs of the residents. Food, fridge and freezer temperatures are not being recorded daily and improvements are required (see criterion 1.3.13.5)  With the exceptions noted food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. 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. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service uses the interRAI assessment tools for the residents. The interRAI assessment, along with the organisational paper based assessment tools serve as a basis for identify needs and developing the care plan (see link criterion 1.3.3.3). The service used additional assessment tools for skin integrity/pressure area risk, falls risk, continence assessment, behaviour management, pain assessments and nutritional assessment. The assessment processes sighted in the resident’s files covered the resident’s physical, psycho-social, cultural and spiritual needs. |
| 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 was consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes (see exceptions link criteria 1.3.3.3. and 1.3.8.2). The care plan format records the resident’s needs, goals/aims and interventions. 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.  Continence evaluations are completed on admission for all residents. Goals for continence are recorded in residents long term care plans. A sample of files was reviewed specifically for continence management and all had appropriate interventions and management plans. Adequate continence products are held on site.  The service conducted a review of the resident’s and family satisfaction in November 2014. The collated results indicated that the service is meeting the needs of the residents. Residents and family/whanau interviewed reported satisfaction with the care and service delivery. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is based on providing motivational activities for the residents. There are specific and modified activities for the higher level of care residents. Group and individual activities are provided.  The diversional therapist (DT) reported that they gauge the response of residents during activities and modified the programme related to resident’s response and interests. The DT reported the activities are 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 DT used the assessments to develop an activities programme that was meaningful to the residents.  An occupational therapist (OT) is employed and they are responsible for the continuation of a plan set by a physiotherapist who visits at least fortnightly. Residents with mobility issues are assessed by the physiotherapist who develops a mobility plan.  Residents are encouraged and supported to participate in a range of community activities and support residents to keep up activities they took part in prior to coming into the service. For residents who are not able to independently participate in community activities, there are a number of community members who regularly visit the service and talk to residents. Two mobility buses are used to take residents to outside groups.  Feedback was sought from residents at the residents meeting and during activities. The residents and family/whanau reported satisfaction with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | The improvements that were required during the last audit with evaluations of resident care plans has not been fully addressed and improvements are still required (see criterion 1.3.8.2).  Evaluations were documented, resident-focused but do not indicate the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. The care plans sighted were developed, reviewed and evaluated at least six monthly.  Short term care plans are used for the management of wounds only.  The residents and family/whanau interviewed reported satisfaction with the care provided at the service. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There have been no building alterations undertaken at the facility since the last audit. Documentation and observations evidenced a current Building Warrant of Fitness is displayed that expires 1 July 2015.  There is a full time maintenance person on site. The maintenance person was interviewed and advised that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person confirmed there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Calibration reports for medical equipment were reviewed. Current electrical safety tags were viewed on electrical items.  Observations of the facility provided evidence of safe storage of medical equipment. Corridors are wide enough to allow residents to safely pass each other; safety rails are secure and are appropriately located.  External areas are available for residents and these are maintained to an adequate standard and are appropriate to the resident groups. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.  Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.  Residents confirmed they know the processes to follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.  A New Zealand Fire Service letter dated1 August 2010 was reviewed and confirmed the fire evacuation scheme was approved. The last trial evacuation was held in February 2015. Staff education in fire safety was provided in December 2014 and twice in February 2015.  There is at least one staff member on duty with a current first aid certificate. Emergency and civil defence education is provided as part of the in-service education programme. This education was last provided in February 2015 and staff interviewed confirmed this. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.  Observations provided evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Observations evidenced emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.  There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner. They also report that the time it takes staff to respond to their call bell has recently improved. The auditors tested the staff response times during this audit and staff responded promptly when the call bells were activated. |
| 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 | The infection control co-ordinator, with the support of the clinical manager (CM), is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) were documented to guide staff. The standardised definitions of infections are appropriate to the long term care setting. Information was collated on a monthly basis. Surveillance was appropriate for the size and nature of the services provided.  Information gathered was clearly documented in the infection log maintained by the infection control co-ordinator. Surveillance for infection was carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes were in place and documented.  The infection control surveillance register included monthly infection logs and antibiotics use. Infections were investigated and appropriate plans of action were sighted in meeting minutes. The surveillance results are presented to the board meeting. Surveillance information is presented to the combined health and safety/quality/infection control meetings.  The infection and surveillance data is collated, analysed, trended and corrective actions implemented to reduce infections where indicated. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has implemented policy and procedures to guide staff in the safe use of restraint. This was confirmed in documentation sighted and during staff and management interviews. Policies identified that the use of enablers is voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety.  There are five residents currently using restraints and three currently using enablers.  The service conducts an annual review of restraint and enabler use (last conducted April 2014). This review recorded the service has been able to minimise restraint use through effective management of challenging behaviours. The staff demonstrated good knowledge on enabler use and strategies for avoiding the use of restraints. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint evaluation is conducted three monthly and the process is well documented. Ongoing restraint use only occurs following a full evaluation. The improvement required from the last audit relating to staff signing of monitoring records has been addressed (criterion 2.2.4.1). |

# 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 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Moderate | Outbreak management report for a recent diarrhoea and vomiting outbreak indicates the outbreak commenced on 2 April 2015 and the last case was on 10 April 2015. The facility was closed on 8 April 2015 and reopened 15 April 2015.  The clinical manager was notified of the outbreak on 4 April 2015 by a registered nurse from the facility. The general manager was made aware of the outbreak on 6 April 2015 and immediately notified the Medical Officer of Health.  Family were advised of the outbreak on 6 April 2015 and again on 10 April 2015. Twenty seven residents and 19 staff were affected.  Outbreak Management policy provides staff with clear guidance on what an outbreak is and the requirement to notify the public health services. | There was a delay in notifying the Medical Officer of Health of a recent gastro-enteritis outbreak. | Provide confirmation that staff are aware of their statutory and/or regulatory obligations in relation to essential notification reporting.  60 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | An appraisal schedule is in place and indicates 10 staff do not have current staff appraisals. Review of staff files indicates three staff do not have current staff appraisals. The general manager advised that the majority of staff did not have current appraisals during the last audit. They also advised the recent Norovirus outbreak has delayed completion of staff appraisals.  The registered nurses, diversional therapist and occupational therapist have current first aid certificates. A register of renewal dates for first aid certificates is maintained. | Not all staff have current performance appraisals. | Provide evidence that all staff have current performance appraisals.  60 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Three nurses were observed at various times during the lunchtime and evening medication rounds. Two of the three had the medication trolley within reach at all times. One of the enrolled nurses did not have the trolley in their line of vision at all times in the dining room. The trolley was observed to be up to 10 metres away from the nurse giving out the lunchtime and evening medications on day one of the audit.  Two staff members were observed on day two of this audit during the lunchtime medication rounds. These staff were observed to keep the trolley beside them and in their line of vision at all times.  Medicine policies and procedures are available.  Each resident file reviewed had an individual medicines profile and medicine prescription form with an individually dispensed medicines and medicine signing sheets. Medicine charts sampled evidenced residents' photo identification, allergies recorded and medicine charts were legible.  Specimen signatures were available. | A staff member was observed leaving the medication trolley unsighted and unattended during the lunchtime and evening meal medication rounds. | Provide confirmation that staff are not leaving the medication trolley unsighted and unattended during the medication rounds.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Medication charts were reviewed with photos and allergies recorded. Medicine administration signing sheets had been signed.  The GP is using ditto marks when writing resident’s medications on their drug chart. Discontinued medications are crossed out on drug chart but not consistently signed for. | Not all medications are reviewed three monthly by the GP  (ii) Each medication on the residents drug chart is not consistently dated and signed for individually.  (iii) When medications are discontinued they are not consistently signed by the GP | Provide evidence that (i) all medications are reviewed three monthly by the GP; (ii) each medication on the residents drug chart is not consistently dated and signed for individually; and (iii) When medications are discontinued they are not consistently signed by the GP  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 Moderate | Temperature recording charts for food, fridge and freezers reviewed. Gaps in the documentation as staff are not recording the temperatures daily. | Food and fridge temperature recordings are not consistently being taken and recorded | Provide evidence that food and fridge temperatures are monitored and recorded daily.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Five resident files reviewed did not have initial care plans. An additional two files for residents who have recently been admitted were reviewed and these have initial care plans.  The restraint register was reviewed and records six residents using restraints and three using enablers. Care plans for these residents were reviewed to ascertain if this fact is recorded in their care plans. | (i)Not all resident files have initial care plans completed on admission.  (ii) Care plans for residents who are using restraints and enablers do not record the fact they are using restraints and / or enablers. | Provide confirmation that (i) all residents have initial care plans completed on admission; and (ii) care plans for residents who are using restraints or enablers record this fact.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Short term care plans / wound management plans are used for residents with wounds.  Care plans have been reviewed six monthly. | (i)With the exception of wounds, short term care plans are not developed for residents who develop an acute condition or have a short term need.  (ii) Evaluations of care plans do not reflect the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | Provide evidence that (i) Short term care plans are being used when residents develop an acute condition or have a short term need; and (ii) evaluations of care plans reflect the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.  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.

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End of the report.