# Arbor House Trust

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Arbor House Trust

**Premises audited:** Arbor House Rest Home

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

**Dates of audit:** Start date: 1 October 2015 End date: 2 October 2015

**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:** 21

# 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

Arbor House is owned and operated by a community trust, and is run by a nurse manager who reports to the board of directors on a monthly basis. The service provides care for up to 21 residents across two service levels (rest home and hospital). The nurse manager has been in her role since May 2014 and a team of registered nurses and experienced care staff supports her.

An unannounced surveillance audit was conducted against the Health and Disability Services Standards and the services funding contract with the local district health board. The audit process included the review of documentation and resident files, observations and interviews. Interviews were conducted with management, staff, residents and family/whānau to verify the documented evidence.

The family members and residents interviewed all spoke positively about the care and support provided.

Two of 20 shortfalls identified at the previous audit have been addressed around open disclosure and adverse event reporting.

While some improvements have been made in relation to the remainder of the findings, further improvements have been identified at this audit. There continues to be improvements required around the complaints process, aspects of the quality programme, essential notification reporting, aspects of human resources, staff orientation and education, documentation of assessments and care plans, activity plans, implementation of medication management system and the quality system, safe food service monitoring, safe storage of chemicals, restraint documentation, aspects of infection surveillance.

## Consumer rights

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

The service has an implemented open disclosure policy. A complaints policy guides staff in the management of complaints.

## 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 medium or high risk and/or unattained and of low risk. |

Arbor House has a risk management plan 2015 – 2017, which includes clinical risks as well as business risks. The nurse manager has maintained professional development activities related to managing a rest home.

There are human resources policies to support recruitment, selection, orientation and training and development of all staff. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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

There are policies and procedures around care planning and registered nurses are responsible for all care planning and documentation. There are three InterRAI competent registered nurses. The service aims to complete all care plans in the new care-planning format and complete all InterRAI assessments.

The service employed an experienced recreation officer and she has been in her current role since March 2015. The activities programme supports residents’ activity and is sufficiently comprehensive to meet the needs of residents. There are policies and procedures around safe medication management. Registered nurses are responsible for medication administration. A dietitian has reviewed the menu. Residents have had a nutritional profile developed on admission.

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

There is a current building warrant of fitness.

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

A restraint minimisation and safe practice policy include comprehensive restraint procedures. There were three residents utilising restraint and two residents with an enabler.

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

The infection control policies, guidelines and procedures are currently under review by the nurse manager. There is an infection control surveillance programme and some improvements have been made in collection and analysis of infection control data.

## 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 | 5 | 0 | 2 | 12 | 0 | 0 |
| **Criteria** | 0 | 20 | 0 | 3 | 19 | 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. | PA Low | Two registered nurses (RN) interviewed, stated that family members are advised on entry to the facility of the complaint processes. Five residents (three hospital and two rest home) and two family members interviewed demonstrated a good understanding of these processes. However, required corrective actions from the previous audit were not fully addressed and this audit identified further issues around complaint documentation. Discussions with the nurse manager confirmed that there have been no complaint investigations by the Health & Disability Commissioner, police or Coroner since the previous audit at this facility. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Ten incident forms were reviewed from July and August 2015. Family were notified or the reason for not contacting family members were documented in all 10 forms reviewed. There is evidence in progress notes that family are notified following a resident incident. Interview with four caregivers and two registered nurses informed families were kept informed. Two hospital family members interviewed confirmed that they are notified following a resident incident. Document reviews and interviews evidenced that open disclosure process is implemented therefore the required corrective action from the previous audit has been addressed. The nurse manager stated that they could access interpreter services if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Arbor House is owned and operated by a community trust. This ‘not for profit’ trust is led by a board of directors.  The service managed by a nurse manager who had been in this role since May 2014. She has a background in emergency nursing, patient services management and previous clinical and non-clinical management experience in a district health board. The nurse manager reports monthly to the community trust board.  The service provides rest home and hospital level care across 26 beds. On the day of audit there were 21 residents (11 rest home and 10 hospital).  There is a documented mission statement and philosophy. The service has a current risk management plan and identifies all risk areas and quality measures.  The manager has maintained professional development activities related to managing a rest home.  The four caregivers and two registered nurses (RNs) interviewed stated that they receive good support from the nurse manager, who is able to provide advice at any time. The nurse manager also undertakes the RN role to cover staff shortages and maintain clinical practice. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | Arbor House has a risk management plan 2015 – 2017. The plan includes clinical risks as well as business risks. There is no separate quality plan in place. The previous surveillance audit identified several issues around the quality and risk management system. The service has made progress and addressed some aspects of these findings. These include staff meetings, analysis of quality data and inclusion of this data in the staff/quality meetings. However not all previous findings have been fully addressed and this audit identified further improvements.  The nurse manager has not fully implemented the new policies purchased from an external aged care policy expert. These policies were also not reviewed in terms of appropriateness to their service setting.  Extensive analysis of falls occurred since the previous audit and these were reported to the staff and the board. Falls prevention strategies are in place that include sensor mats for relevant residents, increased supervision if required for a resident identified as a high falls risk and the identification of interventions on a case by case basis to minimise future falls. |
| 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 Moderate | The service collects incident and accident data and reports aggregated figures monthly to the board and two monthly to the staff meetings. Staff complete incident forms and the resident is reviewed by the RN at the time of the event. Family are notified as appropriate. Ten incident forms reviewed, showed that all incidents were investigated and signed off by the RN or the nurse manager. Long-term and short-term care plans included current care needs and appropriate interventions. Staff interviewed confirmed that incident and accidents were discussed with them. Since the previous audit, the nurse manager analyses data including place and time of incidents, and informs staff for appropriate interventions. These are all improvements since the previous audit, therefore the previous finding around adverse event reporting had been addressed. This audit identified further improvement required around essential notification reporting. |
| 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 Moderate | Arbor House has a total of 36 staff which include seven RNs. There are human resources policies to support recruitment, selection, orientation and training and development of all staff. Seven staff files reviewed did not evidence that all files were completed. The education programme continues to require improvement. A caregiver training programme is facilitated for care staff. The nurse manager stated that she and another RN is enrolled to commence the assessor for the NZQA approved training program for caregivers.  Three RNs (including the manager) have completed InterRAI training. A copy of practising certificates for registered professionals has been maintained. The nurse manager stated that they can access these records online if required. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides coverage across both areas. The RN on duty completes staff duty allocation and resident’s acuity dictates the staff levels and allocation. There is at least one RN on duty 24 hours a day, seven days a week. The nurse manager stated that she works on the floor at least once a week and covers RN absence if required. There is a dedicated laundry and cleaning staff.  The nurse manager works full time. Both the nurse manager and an RN (second in charge) are on call afterhours. The four caregivers and two RNs interviewed confirmed that there is adequate staffing. Residents and two relatives interviewed informed there are sufficient staff on duty at all times. |
| 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 | There are medication management policies and procedures for safe medicine management, which require further implementation. The service uses a blister packed medication system. The medication room is locked when unattended. RNs administer medications. Syringe pumps are organised by the RNs who have completed the required training. The two RNs interviewed confirmed that medicine reconciliation occurs. All medicines received are checked by the RN on arrival. RN interviewed confirmed that any discrepancies are documented and errors fed back to the pharmacy. Ten medication charts sampled have photo identification, allergies/adverse reactions noted and any special instructions for administration on the medicines chart.  Eye drops are dated on opening and the administration of controlled drugs is signed by two staff members. Medication fridge temperatures are monitored and ‘as required’ medications include the reason for use. These aspects of the previous findings have been addressed. Medication administration does not fully meet the requirements and competencies have not been completed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | The kitchen is situated off the dining area and food is directly served from the kitchen. There is a second lounge for residents who require full assistance from staff. On the day of the audit there was one staff member assisting residents with meals. Food was brought to the dining room individually, ensuring that meals are served hot enough.  A dietitian audited the menu in 2015 but there was no evidence that recommendations were followed up (link #1.2.3.8). Residents’ dietary needs are communicated to kitchen staff and all dietary requirements were recorded on the white board. The cook (interviewed) stated that she is informed of any dietary changes. Resident likes and dislikes are known. Normal and pureed meals and alternative choices are offered. There are additional nutritious snacks available 24 hours a day for all residents if required. Improvements required from the previous audit have not been addressed and this audit identified further shortfalls. Five resident files reviewed demonstrated service care plans identify special/modified dietary needs. Residents interviewed confirmed that their individual preferences are catered for and special needs are being met. Two rest home level residents stated that food is always good here and they both look forward to their meals. The cook stated that she is in touch with residents every day and if anyone is not happy with meals she always offers alternatives. Two family members interviewed also stated that they have no concerns around food services. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Staff, resident and family interviews confirmed that provision of services and/or interventions is consistent with residents assessed needs. Documentation around individual provision of services is not yet fully completed. This was a partial attainment from the previous audit and has not yet been fully addressed.  The wound folder was reviewed and included eight wounds and no pressure areas. Wound care documentation has not been fully completed. Continence products are available and specialist continence and wound care advice is available as needed and this could be described by the registered nurse interviewed. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | The service has employed an experienced recreation officer and she has been in her current role since March 2015. She works Monday to Friday from 9am to 4 pm.  The activities programme supports residents’ activity and is sufficiently comprehensive to meet the needs of residents.  The service continues to provide a range of activities for the residents in rest home and hospital care. The same activities programme is used for both the rest home and hospital residents. Four out of five residents files reviewed, had completed records. Discussions with the activities officer confirmed that there are six more resident files to be completed. There are group and individual activities in place that include physical activities, mental stimulation and social stimulation. Activities progress reports are maintained. Van outings were provided for those able to participate and community connections were maintained.  Five residents were interviewed and all were satisfied with their individual and group activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Care plan evaluations were a partial attainment from the previous audit and this has not been addressed yet. The service has implemented a new care-planning format since the previous audit. The new care plans were developed without a review or evaluation of the previous care planning. There were examples where care plans had been updated when needs changed. |
| 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 is a current building warrant of fitness, which expires June 2016. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | PA Moderate | There are policies and procedures around the management of cleaning and laundry services. The previous audit identified issues around the safekeeping of chemicals and this continues to be an issue. This partial attainment has not been addressed. |
| 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. | PA Moderate | The infection control (IC) policies, guidelines and procedures are currently under review by the nurse manager. There is an IC surveillance programme and improvements have been made in the collection of IC data and reporting this data information and IC surveillance activities back to staff. However, the IC programme is not fully implemented. The service had several chest infections effecting a number of residents in September but the service did not comply with their obligation under essential notification reporting (link #1.2.4.2). However, Interview with two RNs and four caregivers confirmed that management of chest infections was appropriately managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Arbor House has policies and procedures on restraint minimisation and safe practice. The nurse manager is the restraint coordinator. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. There were two enablers and three restraints in use on the day of audit. These are all in the form of bed rails. Four caregivers and two RNs interviewed stated that there are no other forms of restraint or enabler used on the day of audit. Interviews with caregivers and RNs confirmed that the use of enablers is voluntary. Residents using enabler’s sign the consent form. One resident file with enabler use reviewed showed that the resident signed the consent form to use bed rails for safety when the resident is in bed. An improvement is required around monitoring of enablers (link # 2.2.3.4). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Moderate | The previous audit identified that there was no documentation of restraint monitoring. A review of two residents with restraint (bedside rails) and one resident using bedsides as an enabler identified that there is no documentation to support restraint or enabler monitoring. This remains a finding from the previous audit. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Moderate | The previous audit identified that restraint evaluations had not been completed six monthly. There continues to be no documented evidence of evaluations for the three resident files reviewed. |

# 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 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The service has appropriate policy and procedures to manage the complaint processes and a register is maintained. Residents and family members are advised on entry to the facility of the complaint processes and resident, family and RN interviews confirmed that this occurs. Five residents and two family members interviewed stated that they have not made any complaints to date yet. Document review confirmed that implementation of the complaint management system does not aligned with Code 10 of the Code of Consumer Rights. | The complaint register includes five complaints from 29 December 2014 to the audit date. The complaint register includes dates around response letter and resolution and nature of the complaint, however, the following issues have been identified: i) in all complaints, the complaint acknowledgement letter does not include the time frame of the investigation process; ii) One complaint did not have any documentation around investigation or a response letter to the complainant as this was dealt with face-to-face; iii) the Health and Disability commissioner or advocacy information or complainant’s right to appeal is not acknowledged when the service replies to complaints; iv) confirmation is not sought to confirm that the complainant is satisfied with the outcome of the complaint. (Advised by the manager that confirmation is sought and acknowledged either face-to-face or via email. Nil outstanding complaints are matters going forward to mediation). | Ensure that the complaint management process is fully implemented.  60 days |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Moderate | The nurse manager undertakes review of all policies and procedures. However, document control system is not fully implemented. | Policy review has yet to be fully completed. Clinical polices are currently under review. The nurse manager had adopted clinical polices provided by an external consultant and these were not fully reviewed in terms of appropriateness to the service. The policies refer to the forms and documents to be used in conjunction with the policies. These forms are not in use. An example of this is forms related to restraint minimisation and wound care. Medication competency forms are in place for caregivers however, caregivers do not administer medication at Arbor House (link # 1.2.7.5). | Ensure that all policies, procedures and associated forms and documents are reviewed and fully implemented.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | The required corrective actions around analysis of quality data, particularly around incident and accidents and infection control, have been addressed. However, there is no documented audit schedule plan. The risk management plan 2015 – 2017 shows identification of risks but this has not been implemented yet. Staff meetings takes place at least two monthly and there is evidence of more frequent meetings and four caregivers interviewed confirmed this. RN meetings occur. This is an improvement since the previous audit but there is a lack of documented evidence around discussion of any issues and follow up process. There is a resident’s advocate who visits and speaks with residents. There has only been one residents meeting held (September 2015) since the previous audit due to resident advocate taking up the role in September | i) Internal audits are not completed; ii) Staff minutes lacks documented evidence around discussions and required corrective actions; iii) Consumer satisfaction surveys are not completed; iv) Only one residents meeting has been held since the previous audit. | i) Ensure that internal audits are completed; ii)) Ensure that staff meeting minutes include discussions around quality data or any other issues and that the follow up process is identified and completed; iii) Ensure that consumer satisfaction surveys are completed; iv) Provide evidence that resident meetings take place as planned.  60 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Moderate | The quality and risk management plan is not fully implemented. There is no current quality plan in place. Quality activities are conducted and include staff meetings and analysis of incidents and accidents. An internal audit schedule is not in place and the complaints management process is not fully implemented (#1.1.13.3). | The quality system is not fully implemented to ensure that quality activities conducted generate opportunities for improvements including an annual quality plan and internal audit schedule. | Ensure that the quality system is fully developed and implemented.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Internal audits conducted are not linked to a quality management system or internal audit schedule. Corrective action planning regarding any identified issues is not directly related to implementation of the quality system. | i) Corrective actions have not been developed for all identified issues. Night staff complete a medication audit but this does not include all medication management compliance requirements, such as signing gaps and prescribing errors around short-term medications. This data was available, but required corrective actions were not identified and implemented. Staff/quality meeting minutes refers to documentation compliance audit but discussions with the nurse manager confirmed that this audit has yet to be completed; ii) The current menu was reviewed by a dietitian in 2015, which included recommendations to the menu. There is no documented evidence that dietitian recommendations have been followed up. The nurse manager was able to confirm that changes have been made to the menu. | i) Ensure that action plans are generated as required; ii) Provide documented evidence that recommendations from the dietitian are followed up and adjustments made to the menu.  60 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Moderate | There is a hazard register for the various aspects of the service. This has not been updated since 2013. | The hazard register is not current and does not include all hazards. | Ensure that the hazard register is up to date and reviewed regularly.  60 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 | Interviews with the nurse manager confirmed that she was not aware of her responsibility around essential notification reporting. | In September 2015, chest infections affected residents. Individual infection reports shows 13 chest infections and some of these were repetitive infections. Review of medical faxes to the GP showed that the RN recorded that the service may have an outbreak. Four caregivers interviewed also confirmed that several residents had a chest infection in September. Discussions with the nurse manager confirmed that public health authorities and the local DHB were not notified. | Ensure that essential notification reporting occurs.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Seven staff files reviewed included two RNs, four caregivers and one activities coordinator. Two of seven staff files reviewed evidenced that staff annual performance appraisals have been completed. All staff files reviewed had job descriptions and these were signed-off by staff. This is an improvement since the previous audit. Advised that seven staff appraisals have been completed since May 2015, with links to education requirements. | Five files out of seven did not have annual staff appraisals records. | Ensure that staff appraisals are completed annually.  180 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | Staff and the nurse manager interviewed confirmed that the orientation programme has been implemented. Two of seven staff files evidenced completed orientation records. | Five out of seven staff files did not have completed staff orientation records. | Ensure that staff orientation records are maintained.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | The nurse manager developed a two yearly education plan. This is an improvement since the previous audit. Further improvements are required around implementation of the staff-training programme. Competencies for registered nurses and care staff are not fully completed (link #1.3.12.3). The nurse manager showed an example of medicine competency designed for caregivers; however, the caregivers do not administer medication at Arbor House. Further competencies for care staff have not been completed. | There is a new staff-training plan in place and the plan includes all required sessions with the exception of Treaty of Waitangi – cultural safety. i) Advised by the nurse manager that culturally safe care training was conducted in 2014, however, training records and content of the session was not maintained, therefore this could not be confirmed; ii) The nurse manager stated that scheduled training occurs but staff training attendance recorded on an excel sheet shows very low staff attendance. Staff interview confirmed that two staff had less than three hours training in the last year and two staff did not participated in-services during this period as were new to Arbor House; iii) There are no competencies to confirm that training provided has been effective and staff knowledge around the training provided is not tested. | i) Ensure that Treaty of Waitangi – cultural safety is included in the staff training plan; ii) Ensure that at least eight hours of training is provided to all staff; iii) Provide evidence that competencies are developed, ensuring that staff training is effective.  90 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 | The medication management system complies with requirements in terms of storage, charting, allergies, and photographs for identification. Seven of 10 medication charts evidence three monthly medication reviews by a GP. Three of 10 medication signing sheets are completed appropriately. | i) Ensure that medications are signed for as administered and that ‘not given’ medications are documented appropriately. ii) Ensure that prescriber includes a start and finish date for short course medications. iii) Ensure that standing orders are reviewed and comply with current medication guidelines. iv) Ensure that all expired medications are returned to the pharmacy. v) Ensure that three monthly medication reviews are signed off by the GP. | i) Ensure that medications are signed for as administered and that ‘not given’ medications are documented appropriately. ii) Ensure that prescriber includes a start and finish date for short course medications. iii) Ensure that standing orders are reviewed and comply with current medication guidelines. iv) Ensure that all expired medications are returned to the pharmacy. v) Ensure that three monthly medication reviews are signed off by the GP.  60 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | There is a medication competency assessment tool available for carers. Only RNs administer medication at Abor House. The manager advised that competencies were completed Dec 2014. Tests held with individual RN, documented on education planner. There was no documented evidence of these being completed on file. | Registered nurses did not have a current medication competency completed on file. | Ensure staff that administer medications complete a medication competency and that this is reviewed annually.  60 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There are policies and procedures around safe self-administration of medicines by the residents. Staff stated that one resident administers inhalers. | i) Self-medication competency is not completed for one resident who administers inhalers. ii) Monitoring of self-medication administration is not recorded. | i) Ensure that self-medication competency is completed and reviewed three monthly. ii) Ensure that monitoring of self-medication administration is recorded.  30 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 | Food temperatures are recorded regularly and this is an improvement since the previous audit. Fridge and freezer temperatures were not consistently recorded. Interview with the cook confirmed that all stock is checked on arrival ensuring that original packaging is not damaged. All dry foods were appropriately stored. Cooked meals and other food in the fridge were covered and dated. | i) Fridge and freezer temperatures are not being recorded on a daily basis. Particularly in the last three days prior to audit, the cook was unable to find the fridge thermometer. ii) The wooden drawers and cupboards are damaged/chipped making surfaces difficult to clean. iii) Staff involved in food preparation do not have current food hygiene and safety certificates. | i) Ensure that monitoring of fridge and freezer temperatures are routinely checked and recorded. Ii) Repair or replace wooden surfaces to ensure food hygiene standards are not compromised; iii) Ensure that all staff who are involved in food preparation have current safe food handling certificates.  60 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 | Care plan documentation and timeframes are still a work in progress. One resident file included pain assessments but not all residents requiring pain analgesia have a pain assessment completed. Family involvement was included in the care plans and in the InterRAI assessments. This is an improvement since the previous audit. | Five resident files were reviewed (two rest home and three hospital). i) One hospital resident requiring regular and ‘as required’ analgesia had no pain assessments completed. ii) In one rest home file, paper based assessments were completed two months after the entry to the service. iii) In one rest home file, the admission by the GP was not dated and two rest home files evidenced that the GP had not seen the residents within two working days. iv) One hospital resident’s long-term care plan was not dated, therefore unable to verify that the care plan had been developed within 21 days of admission. One rest home resident had care planning completed three months after entry to the service; v) There are still no assessments completed for the use of an enabler or for two residents with restraints; vi) One rest home resident did not have a long-term care plan in place. | i) Ensure that pain assessments are completed for residents requiring regular and as required analgesia; ii) Ensure that all assessments are completed with 21 days of admission; iii) Ensure that all residents are seen by a GP within two working days of admission; iv) Ensure that all documents including long-term care plans are dated and care planning is completed within 21 day of admission; v) Ensure assessments are completed for residents utilising enablers and restraints; and vi) provide evidence that all residents have a long-term care plan in place to guide staff in the provision of care.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Five residents interviewed confirmed their current care and treatments they are receiving meet their needs. Two family interviews also confirmed residents are assessed and required interventions are implemented. Four caregivers interviewed were knowledgeable around residents’ current nursing cares and they described the written and verbal handover process and felt that they were well informed by the RNs around sudden changes in resident’s health condition. In the sample of files reviewed, it is noted that not all care plans were comprehensive and not all were consistent with InterRAI assessments. Residents’ previous health history and medical risk management plans were well documented on the InterRAI assessments and included in the care plans. Monthly weighs or observations were evident in the file reviewed. One resident had a weight loss and the reason for this was known and expected. However, this finding has not been fully addressed yet. | i) One hospital resident has pain and the potential for acute health issues. The issues have been triggered on the InterRAI assessment, but the care plan does not refer to any interventions. Staff interview confirmed that the resident had shoulder pain; ii) In one hospital file the care plan does not refer to restraint use and monitoring requirements; iii) Wound assessments and wound monitoring forms were not fully completed for all wounds. The wound folder included several wounds and discussions with an RN confirmed that not all wounds were current. She stated that some of the wounds were already healed not requiring dressing but this was not documented. One wound chart was requiring daily dressing and status of the wound was “inflamed” but this has not been followed up since 27 September 2015; iv) One resident requiring weekly blood sugar level monitoring has not has this completed regularly and another resident with diabetes also had irregular blood sugar monitoring. Care plans did not include frequency of blood sugar monitoring; v) One hospital resident record showed an eight kilogram weight loss between first weighing in June to the second weighing in September 2015, with no record of assessment or care plan interventions. | i), ii) Ensure that care plan interventions are consistent with residents assessed needs iii) Ensure that wound care documentation is consistent with current wound management; iv) Ensure monitoring of blood sugar levels are documented and frequency of blood sugar monitoring is documented in the care plans; v) ensure that residents with weight loss are assessed and monitored and care plan interventions reflect the care requirements.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Four out of five resident files reviewed had completed activities documentation. The recreation officer has made progress to update 15 residents files however, discussions confirmed that six more files need to be completed and one of these file did not have an individual activities assessment and related documentation. | Not all residents’ files have up to date activities documentation. | Ensure that all residents have an individual activities plan and complete documentation around this.  180 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 | Care plans in place (link #1.3.3.3), have been updated to reflect the new documentation. One care plan is not yet due for review. | Five files were reviewed (two rest home and three hospital). One hospital file was not yet due and all other files did not have care plan evaluations. | Ensure that care plans are evaluated and updated six monthly and as needed.  60 days |
| Criterion 1.4.6.3  Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | PA Moderate | There is a designated chemical storage area and some chemicals are kept in the laundry. Staff interviewed confirmed that chemical safety training is provided and cleaning staff were observed using chemicals safely. | Chemicals were stored in the laundry and chemical storage cabinet, however the laundry door and the storage cabinet do not have a lock for safe keeping. | Ensure that all chemicals are safely stored.  30 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Moderate | There is a policy describing surveillance methodology for monitoring of infections. The nurse manager stated that the policies and IC programme is currently under review. (See CAR 1.2.3). The infection control coordinator is the nurse manager and mentors one of the RNs to undertake this role. Since the previous audit, individual infection forms have been completed for each resident with an identified infection. Infection control data is reported back to the board and discussed at the staff/quality meetings. This is an improvement since the previous audit. Staff interview confirmed discussion of IC data in the staff meeting and more frequently during handovers. However, further improvements are required around IC surveillance. There is close liaison with the GPs that advise and provide feedback/information to the service. This was evidenced in the RN interview and faxes to the GPs practices regarding notification and advice around IC issues. | i) Detailed information on the type of infections, treatment, duration of treatment and its effectiveness has not been recorded. ii) Toilet/bathroom vinyl was broken (under the toilet seat) in the old part of the building which can cause an infection control issue. | i) Ensure that detailed information on the type of infections, treatment, duration of treatment and its effectiveness is recorded. ii) Ensure that bathroom/toilet vinyl is repaired.  60 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Moderate | Restraint minimisation policies and procedures describe an approval process, approved restraints and the restraint assessment identifies specific interventions or strategies before using restraint. Three resident files were reviewed, two with restraint and one with an enabler. The residents all have appropriate consent forms in place but monitoring of restraint was not documented and assessed. | i) There was no documented evidence of monitoring for the two restraints and one enabler. One resident file stated two hourly monitoring of bed rails and the other two care plans did not include restraint monitoring. | i) Ensure that monitoring of the resident with restraint and enablers occurs and is documented.  60 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Moderate | There is a restraint evaluation form but this form was not utilised. Care plan reviews also did not include restraint evaluations. | i) There was no documented evaluation of restraint/enabler use being completed. ii) The restraint register has not been maintained. | i) Ensure that restraint/enabler use is evaluated individually. ii) Ensure that the restraint register is maintained.  60 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.