

# Prasad Family Foundation Limited

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## 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](#).

The specifics of this audit included:

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| <b>Legal entity:</b>  | Prasad Family Foundation Limited   |
| <b>Premises audited:</b>  | Brylyn Residential Care  |
| <b>Services audited:</b>  | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| <b>Dates of audit:</b>  | Start date: 19 February 2016      End date: 19 February 2016   |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 27   |

# Executive summary of the audit

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## 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         |

| Indicator | Description  | Definition  |
|-----------|--|---|
| Yellow    | 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 |
| Red       | 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

Brylyn Residential Care provides rest home and hospital level care for up to 32 residents and on the day of the audit there were 27 residents. The service is managed by a clinical nurse manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service has addressed 10 of 16 shortfalls from the previous certification audit around advocacy services; professional development for the clinical nurse manager; the appointment of staff; staff induction; staff rosters; the timely entering of resident information; security of resident information; staff signatures and designations in residents' files; entry to the service and staff training around emergency procedures.

Further improvements continue to be required in relation to updating policies and procedures to reflect the current environment; the internal audit schedule; corrective action planning; care plan evaluations; medicine management; and medical equipment testing.

This surveillance audit identified that improvements are required in relation to open disclosure; the complaints policy; the complaints register; annual performance appraisals; food safety training; interRAI assessments; and short term care plans.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |
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Advocacy services information is provided to residents and families during their entry to the service. A record of communication with family is held in the residents' files. The right of the resident and/or their family to make a complaint is respected by the service.

## 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. |
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Services are planned, coordinated and are appropriate to the needs of the residents. Annual business goals are documented. Meetings are held to discuss quality activities. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. All new staff undergo a period of orientation. Regular education and in service training are in place for staff.

Registered nursing cover is provided 24 hours a day, seven days a week. The residents' files are appropriate to the service type.

## 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. |
|--|--|--|

Initial assessments and care plans are completed by the registered nurse. Care plans are written in a way that enables all staff to clearly follow instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. A general practitioner reviews each resident at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

## 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 low risk. |
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The building has a current warrant of fitness. Electrical safety checks have recently been completed. A minimum of one staff is available at all times who is trained in first aid and CPR.

## 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. |
|---|--|--|

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. No residents were using restraints or enablers at the time of the audit.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The type of infection control surveillance is appropriate for the size and complexity of the service. Effective monitoring is the responsibility of the infection control co-ordinator. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 11                  | 0  | 7                                    | 2  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 34                  | 0  | 9                                    | 2  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome  | Attainment Rating | Audit Evidence  |
|--|-------------------|---|
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | PA Low            | <p>The complaints policy and procedure does not include guidelines set forth by the Health and Disability Commissioner (HDC) (link #1.2.3.3).</p> <p>Health and Disability Commissioner complaints brochures are provided to families and residents during entry to the service. Complaints forms and a suggestion box are held at reception. Interviews with residents and relatives indicated that they are aware of the complaints forms that are available at reception. Discussions with residents and families confirmed they were comfortable speaking with the clinical nurse manager/RN if they have a concern and that concerns were promptly dealt with. However, three of four resident/family satisfaction survey results indicated that residents/families do not know how to make a complaint. No corrective action plans were developed around this finding (link #1.2.3.8).</p> <p>A suggestions box and complaints forms are located in a visible location at the entrance to the facility.</p> <p>The clinical nurse manager reported that there have been no complaints lodged and therefore no complaints register is held. But one issue/complaint lodged via email to the owner and passed on to the manager was sighted by the auditor.</p> |
| <p>Standard 1.1.2: Consumer Rights</p>   | FA                | <p>The Code of Health and Disability Consumers' Rights (the Code) posters and brochures are displayed in public areas of the facility. The information pack given to prospective and admitted residents and their families includes</p>   |

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| <p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>   |               | <p>pamphlets on the Nationwide Health and Disability Advocacy Service. This is an improvement from the previous audit.</p>  |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>PA Low</p> | <p>Policies and procedures relating to accident/incidents and open disclosure identify staff responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on a family/whānau communication sheet. Communication is also documented on accident/incident forms although was not evident during instances of falls without injury and skin tears. Three family interviewed (one rest home and two hospital) stated that they are kept informed when their family member's health status changes.</p> <p>Contact details of available interpreters are available. Staff and family assist as they are able. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.</p>   |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p>     | <p>Brylyn Residential Care provides care for up to 32 residents. Twenty two beds are certified for rest home level care and ten beds are certified for hospital level care. At the time of the audit, there were 17 rest home level residents and 10 hospital level residents. One rest home level resident is on the Young Persons with Disability (YPD) contract. Two rest home level residents were receiving respite services.</p> <p>Brylyn Residential Care is privately owned. A business plan and a quality and risk management plan are developed each year. These documents are regularly reviewed by the owner and clinical nurse manager.</p> <p>The clinical nurse manager is a registered nurse who has held this post since November 2014. She has worked in the aged care industry as a registered nurse since 2009 and has been employed as a registered nurse for 15 years. She meets fortnightly with the owner.</p> <p>The clinical nurse manager has maintained a minimum of eight hours annually of professional development activities related to managing an aged care service. This is an improvement from the previous audit.</p> |
| <p>Standard 1.2.3: Quality And Risk Management</p>  | <p>PA Low</p> | <p>The quality and risk management programme is guided by a philosophy, objectives, systems and responsibilities. Interviews with the clinical nurse manager, two caregivers, one RN, one cleaner, one cook and one activities coordinator, reflected their understanding of the quality and risk management programme.</p>   |

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| <p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>   |               | <p>Not all policies and procedures and associated implementation systems have been updated to include reference to interRAI for an aged care service and the complaints process as determined by the Health and Disability Commissioner. A document control system has been implemented. This is an improvement from the previous audit. Policies are reviewed three-yearly at a minimum.</p> <p>Adverse event data collected (e.g. falls, medication errors, skin tears) are collated and reported in staff meetings and in monthly tool box talks (impromptu education sessions during handover) with care staff. Not all internal audits have been completed as per the planned audit schedule and outcomes of audits are not included in staff meeting minutes. Corrective action plans have not been developed for all shortfalls identified. These previous findings remain.</p> <p>Falls prevention strategies include identifying residents who are at risk of falling and ensuring supervision is in place for those residents who require assistance. Staff investigate falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Extra low beds and sensor mats are utilised.</p> <p>A health and safety programme is in place. Two health and safety representatives have been identified. Hazard identification forms and a hazard register are in place. Staff orientation covers health and safety.</p> |
| <p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>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.</p> | <p>FA</p>     | <p>Individual adverse event reports are completed for each incident/accident with immediate action noted including any follow up action(s) required (link to 1.1.9.1). Incident/accident data is linked to the organisation's quality and risk management programme. Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and appropriate follow up by a registered nurse.</p> <p>The clinical nurse manager is aware of the responsibility to notify relevant authorities in relation to essential notifications. This was evidenced during an infectious outbreak in November 2015.</p>   |
| <p><b>Standard 1.2.7: Human Resource Management</b></p>  | <p>PA Low</p> | <p>Human resources policies support recruitment practices. Health professional practising certificates are on file. Five staff files were reviewed (two caregivers, three registered nurses). Sighted was evidence of interviews and reference checking. This is an improvement from the previous audit. Signed employment contracts and job</p>  |

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| <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>   |           | <p>descriptions were also sighted. Performance appraisals have not taken place for over one year.</p> <p>Evidence of an orientation programme specific to the role and responsibilities of the position was evidenced. Interviews with staff confirmed the orientation programme is comprehensive. This is an improvement from the previous audit.</p> <p>The education programme meets the requirements of the Aged Residential Care contract and includes internal and external speakers. Education and training for registered nursing (RN) staff is supported by the Waikato District Health Board. Two RN's have completed their interRAI training. Chemical safety training has taken place. Staff trained in first aid/CPR training are available 24/7. Impromptu education sessions (tool box talks) have been implemented during staff handovers, are minuted and take place a minimum of monthly. Food safety training is not up to date for applicable staff.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>      | <p>FA</p> | <p>The staffing levels meet contractual requirements. The clinical nurse manager is an RN who is available during weekdays. A second RN assists her 1-2 days a week. This is an improvement from the previous audit.</p> <p>RN cover is provided onsite 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>   |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>The resident files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in secure areas. Archived records are stored securely. Entries are legible, dated and signed by the relevant caregiver or registered nurse and include the date and time of entry and the staff member's designation. These are improvements from the previous audit.</p>   |

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| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p>              | <p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The admission pack reviewed contained accurate information. The manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical co-ordinator. The admission agreement has been reviewed by the owner and the clinical nurse manager and now meets the standards of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Four of four files of residents admitted in 2015 contained admission agreements that were signed on the day of admission. These findings from the previous audit have now been addressed.</p>   |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>              | <p>PA<br/>Moderate</p> | <p>Medications are administered by registered nurses (RNs) only. The RNs have completed annual medication competencies and medication education. One RN interviewed was able to describe her role in regard to medicine administration. The RN was observed administering medications safely. There were no self-medicating residents at the time of the audit. Medications were securely and appropriately stored. The service does not use standing orders. The service uses blister packs for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Ten medication charts reviewed (six rest home and four hospital) were legible. Medication charts did not consistently evidence photograph identification or that allergies were documented. These previous audit findings remain.</p> <p>Nine of ten charts evidenced that the GP had reviewed the residents' medications three monthly and this remains a finding. Ten charts reviewed evidenced 'as required' medication was charted correctly. This aspect of the previous audit finding has been addressed. Signing sheets reviewed did not match all medication charts in use. This previous finding remains an improvement. An enteral feeding regime for one resident was evidenced on the medication chart. This aspect of the previous finding has now been addressed.</p> <p>Not all medications were evidenced as having been given as prescribed and transcribing was noted to have occurred. Not all medications being administered aligned with a signed prescription from a medical practitioner.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>  | <p>FA</p>              | <p>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RN and care staff. The cook had completed food safety training but the kitchen hand who prepares the breakfast had not completed any food safety training (link 1.2.7.5). The cook stated at interview that the menus are reviewed by a dietitian and documented evidence of this was viewed on the day on the audit. The temperatures of refrigerators, freezers and cooked foods are monitored</p>   |

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| <p>and nutritional needs are met where this service is a component of service delivery.</p>   |                        | <p>and recorded daily. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were satisfied with the quality and variety of food served.</p>   |
| <p>Standard 1.3.6:<br/>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>  | <p>PA<br/>Moderate</p> | <p>Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence products are available and residents' files include a urinary continence assessment, bowel management and continence products identified for day use, night use, and other management.</p> <p>Wound assessments were not in place for all wounds reviewed on the day of the audit. Wound management plans were in place for six of six wounds reviewed. The wound management plans include the timeframe for review of the wounds. Not all wounds had not been reviewed in the stated timeframe. The registered nurse interviewed described the referral process should they require assistance from a wound specialist.</p> <p>Registered nurses (RNs) and caregivers follow the care plan and the RN's and care givers report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral. If external medical advice is required this will be actioned by the GP. Specialist continence advice is available as needed and this could be described. Not all care plans recorded interventions for all identified needs.</p> <p>Care plan interventions including turns were recorded in the progress notes.</p> |
| <p>Standard 1.3.7:<br/>Planned Activities</p> <p>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.</p> | <p>FA</p>              | <p>The service has an activities coordinator who works 25 hours a week and is currently completing a diversional therapist qualification. The service has a five day week programme and activities were observed as occurring. One-on-one time occurs on an individual basis for those residents who choose not to participate in activities. Care staff are also involved in activities. There are a variety of activities provided including entertainment, bingo, crafts and quizzes. Participation is voluntary. Residents enjoy weekly outings in a hired van. Community links are maintained with groups including local schools and individual visitors. There are church services two times a month. There is a residents meeting held three monthly.</p>   |
| <p>Standard 1.3.8:<br/>Evaluation Consumers' service</p>  | <p>PA Low</p>          | <p>All initial care plans were evaluated by the registered nurse within three weeks of admission in files sampled. Regular reviews as specified in the ARC contract are not occurring in these files. This remains a finding from the previous audit. There was at least a three monthly review by the GP in these files. Not all changes in health status were documented and followed up (link 1.3.3.3). Short term care plans were evaluated and resolved or added to</p>  |

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| <p>delivery plans are evaluated in a comprehensive and timely manner.</p>  |               | <p>the long term care plan if the problem is on-going in resident files sampled. Where progress is different from expected, the service has not always responded with initiating changes to the care plan (link #1.3.6.1).</p>  |
| <p>Standard 1.4.2:<br/>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>           | <p>PA Low</p> | <p>The building has a current building warrant of fitness posted in a visible location. There is a part time maintenance person employed to address the reactive and planned maintenance programme. Medical equipment had not been checked and/or calibrated within the last 12 months but electrical safety testing was completed in February 2016. This area for improvement remains. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p>  |
| <p>Standard 1.4.7:<br/>Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>                    | <p>FA</p>     | <p>Appropriate training, information and equipment for responding to emergencies are provided. Fire evacuations are held six monthly. There is a minimum of one staff available onsite 24 hours a day, seven days a week with a current first aid/CPR certificate. This is an improvement from the previous audit.</p> <p>Civil defence and emergency policies and procedures are in place. The facility is well prepared for civil emergencies and has emergency lighting. A store of emergency water is kept. There is a gas BBQ for alternative cooking. Emergency food supplies are sufficient for three days. Extra blankets are available.</p>  |
| <p>Standard 3.5:<br/>Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p> | <p>FA</p>     | <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. An outbreak in November 2015 was appropriately managed.</p> |

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| control programme.   |    |   |
| <p>Standard 2.1.1:<br/>Restraint<br/>minimisation</p> <p>Services demonstrate<br/>that the use of<br/>restraint is actively<br/>minimised.</p> | FA | <p>The restraint policy includes the definitions of restraints and enablers and restraint procedures. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had no residents using enablers or restraints.</p> |

## 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)  |
|--|-------------------|---|---|---|
| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low            | The clinical nurse manager reported that no complaints have been received and therefore no complaints register is in place. It was later discovered during the audit that an issue (complaint) had been received by the owner and forwarded via email to the clinical nurse manager relating to a resident’s cares. | An email sent by a resident’s family was received by the owner in December 2015 relating to a resident’s cares. This was forwarded to the clinical nurse manager who dealt with the complaint through the staff performance appraisal process. This complaint was not lodged in a complaints register. Nor was there evidence that the complaint had been actioned in accordance with HDC requirements. | <p>Ensure an up-to-date complaints register is maintained that includes all complaints, dates and actions taken.</p> <p>90 days</p> |
| <p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open</p>  | PA Low            | Communication with families and residents were evident via resident/family meetings, in residents’ files (family/whānau communication sheet), interviews with five residents (two rest home and three hospital) and relatives. Evidence of open   | Eight of thirteen accident/incident forms, corresponding progress notes and family communication sheets, did not reflect evidence of open disclosure following a minor adverse event (e.g.  | Ensure families are kept informed of all adverse events including minor ones unless directed otherwise by the resident.             |

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| disclosure from service providers.  |        | disclosure was missing in a sample of accident/incident forms.  | skin tear, fall without injury).   | 90 days   |
| <p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p> | PA Low | Policies and procedures are developed and reviewed. Clinical related policies link to the care planning. InterRAI assessment policies and complaints management policies do not meet requirements and the complaints policy lacks full details on how the complaints are managed. | i) The complaints policy and procedure is missing detail on how to deal with complaints; and ii) InterRAI assessment tool policy and procedures have not been developed.   | <p>i) Ensure that the complaints policy and procedure describes and meets HDC requirements (e.g. timeframes for responding to complaints); ii) Ensure policies and procedures are developed around the interRAI assessment tool.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>  | PA Low | Adverse event data is collected, analysed and shared with staff. An internal audit schedule is in place but the audit schedule is not being followed. Staff are not kept informed of internal audit results.  | i)The 2015 internal audit schedule lists 25 audits but only three were conducted in 2015 and none have been undertaken year-to-date for 2016; and ii) Staff have not been kept informed of internal audit results. | <p>i) Ensure internal audits are conducted as per the internal audit schedule; and ii) ensure that staff are kept informed of internal audit results.</p> <p>90 days</p>  |

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| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | <p>PA Low</p>      | <p>Corrective action plans are developed and implemented around adverse event data (falls, infections, skin tears and medication errors). There is evidence of these corrective action plans being reviewed and evaluated. Correction action plans have not been developed around internal audit results or outcomes of the resident/family survey.</p>  | <p>Corrective action plans have not been developed for shortfalls in service delivery, including resident/family satisfaction results and clinical records internal audits.</p>  | <p>Ensure that corrective action plans are developed and evaluated where indicated.</p> <p>90 days</p>   |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>       | <p>PA Low</p>      | <p>An education and training calendar is in place with evidence of regular in-service training. Monthly impromptu toolbox talks are linked to staff handovers and the quality and risk management programme. Staff regularly attend education sessions with individual staff training records maintained.</p> <p>The kitchen hand has not completed food safety training and staff have not had annual performance evaluations conducted.</p>  | <p>i) Performance evaluations have not taken place for over one year. The clinical nurse manager reports that she is aware of this shortfall and was in the process of organising appraisals with staff; and ii) the kitchen hand who prepares the breakfast had not completed any food safety training.</p>   | <p>i) Ensure annual staff performance appraisals are conducted; and ii) Ensure that staff who are responsible for preparing food, hold a food safety qualification.</p> <p>90 days</p>   |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage,</p>            | <p>PA Moderate</p> | <p>One resident who was being administered warfarin did not have a current signed GP order. Faxed instructions were received but these were not signed by the GP. One resident who was prescribed vitamin B12 three monthly was receiving it more frequently than three monthly because staff had transcribed the instructions incorrectly on to the signing sheet. The manager informed the GP of the error on the day of the audit. In four charts reviewed medication was given as prescribed. Four charts reviewed</p> | <p>(i) One resident receiving warfarin did not have a current signed medication order by the GP; (ii) one resident was not receiving vitamin B12 as prescribed and in six charts reviewed medications were not recorded as given as prescribed; (iii) there was evidence of transcribing of B12 orders on the medication signing sheet; (iv) photographic identification was not evident in six charts reviewed; (v) the</p> | <p>(i) Ensure that all administered medication has a current signed prescription, (ii) ensure that all medication is given as prescribed, (iii) Transcribing must not occur, (iv) all medication charts must evidence current photographic identification, (v) all</p> |

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| disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.   |             | evidenced photographic identification. Two charts reviewed evidenced the allergy status of the resident. Nine charts reviewed evidenced that the GP reviewed the medication at least three monthly.   | allergy status of the resident was not recorded in eight charts reviewed; and (vi) in one chart it was not evidenced that the GP had reviewed the chart at least three monthly.  | medication charts must state the allergy status of the resident and (vi) ensure GP's review resident's medications at least three monthly.<br><br>30 days  |
| Criterion 1.3.3.3<br>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 Low      | The registered nurse completes initial assessments and an initial care plan on admission. InterRAI assessments were not completed for new admissions or for residents with significant changes to their health status. Long term care plans were completed within 21 days of admission. Three of four residents' files had risk assessments completed six monthly or as required.   | (i) Two of two new residents admitted since 1 July 2015 did not have an interRAI assessment completed within 21 days of admission; (ii) one hospital resident with a significant change to their health status did not have an interRAI assessment completed; and (iii) One rest home resident did not have assessments completed six monthly.   | (i) Ensure that all new admissions have an interRAI assessment completed within 21 days of admission; (ii) Ensure that all residents with a significant change to their health status have an interRAI assessment completed; and (iii) Ensure that all residents have assessments completed at least six monthly,<br><br>60 days |
| Criterion 1.3.6.1<br>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired                                  | PA Moderate | The caregivers confirmed that the care plans are easy to follow and that the RN's keep them informed of changes to the residents' care needs. Four of six wounds reviewed had a completed wound assessment. Six of six wounds reviewed had a wound management plan including a time frame for the review of the wound. Two of six wounds were reviewed within the stated timeframe. Three of five files reviewed had care plans that reflected the current needs of the | (i) Two of six wounds did not have a completed wound assessment; (ii) four of six wounds were not reviewed within the stated timeframe; (iii) one rest home resident with identified challenging behaviours did not have any management strategies detailed in their care plan; and (iv) one hospital resident did not have their care plan updated to reflect their current needs following a | (i) Ensure that all wounds have a completed wound assessment; (ii) ensure all wounds are reviewed within the stated timeframe; (iii) Ensure that residents with identified challenging behaviours have management strategies   |

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| outcomes.   |        | resident.   | change in health status.   | detailed in their care plan; and (iv) ensure that all care plans are updated to reflect changes in resident's needs.<br><br>60 days |
| Criterion 1.3.8.2<br>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 Low | In two of four files reviewed (one was a respite and had only been at the service for two days) the registered nurses completed a monthly review of the residents care plan. These reviews did not indicate the degree of progress towards meeting the desired outcome. | Two of four (one rest home and one hospital) long term care plans have not been reviewed as specified in the ARC contract. | Ensure evaluations are completed at least six monthly, to state the progress towards meeting the desired outcome.<br><br>90 days    |
| Criterion 1.4.2.1<br>All buildings, plant, and equipment comply with legislation.   | PA Low | A current building warrant of fitness is posted in a visible location (expiry date 20 September 2016). Electrical equipment was tested and tagged in February 2016. Calibration and checks of medical equipment are overdue.  | Residents' scales and medical equipment are due for biomedical calibration.  | Ensure all medical equipment is checked and calibrated annually by an appropriate external service provider.<br><br>90 days         |

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

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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, there 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.