# Montecillo Veterans Home and Hospital Limited - Montecillo Veterans Home and Hospital

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

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

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

The specifics of this audit included:

**Legal entity:** Montecillo Veterans Home and Hospital Limited

**Premises audited:** Montecillo Veterans Home and Hospital

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

**Dates of audit:** Start date: 16 May 2016 End date: 17 May 2016

**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:** 41

# 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

Montecillo Veterans Home and Hospital Ltd provides hospital (medical and geriatric) and rest home level care to veteran men and women and their dependants. The service provides care for up to 44 residents with 41 residents on the day of audit.

A chief executive officer and a nurse manager manage the service. Experienced registered nurses and care staff provide support. Family and residents interviewed all spoke very positively about the care and support provided.

This certification audit was conducted against the 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, general practitioner and staff.

The audit identified that improvements are required around open disclosure policy, survey analysis, timeframes for care planning, aspects of care planning and interventions, activities plans, medication documentation and first aid training.

## Consumer rights

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

Montecillo provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Residents and family interviewed verified ongoing involvement with community. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code.

## Organisational management

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

Montecillo is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted. Corrective actions are developed and implemented. The service has a culture of health and safety. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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. |

Residents are assessed on entry to the service. There are entry and admission procedures in place that include InterRAI assessments. The registered nurses develop care plans. They also have the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident. Family involvement is included where appropriate and care plans are evaluated six monthly or more frequently when clinically indicated. The medication management system in place follows recognised standards and each resident is reviewed at least three monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared onsite and the kitchen is the hub of the rest home. A meal menu plan is in place, which is reviewed by a dietitian. Residents’ food preferences are accommodated and the residents and relatives report satisfaction with the food service.

## Safe and appropriate environment

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

The service displays a current building warrant of fitness. Furniture and fittings are selected with consideration to residents’ abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. There is a designated laundry, with secure storage of cleaning and laundry chemicals. Policies and procedures are in place for essential, emergency and security services, with adequate supplies, should a disaster occur. Communal living areas and resident rooms are appropriately heated and ventilated.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had nine residents using restraint in the form of bedrails or lap belts and three residents with bedrails as an enabler.

## 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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

## 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 | 44 | 0 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 5 | 2 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Montecillo has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Five nurse aides, one activities coordinator, three registered nurses (RN) and the nurse manager were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with eight residents (four rest home and four hospital). |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents including outings, in all seven resident files sampled (three rest home and four hospital level of care residents including one respite resident). Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed.  Discussions with nurse aides and registered nurses (RN) confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative’s lives.  Informed consent processes are also reviewed through the six monthly MDT meeting with residents and relatives and links to the quality system through annual satisfaction surveys. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy is discussed at resident meetings and information is available along with complaints forms and process.  Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents’ family and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirm the staff help them access community groups. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The chief executive officer leads the investigation of concerns/complaints with input from the nurse manager for clinical and care issues. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. Five complaints from 2015 and two from 2016 were reviewed. These have been appropriately managed, with acknowledgement letters, letters of investigations conducted and outcomes achieved provided to complainants. The complaints register is up to date. Management operate an ‘open door’ policy. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. The hospital residents and relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the signed service agreements. Residents and relatives interviewed confirmed they received all the relevant information during admission. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process, with family involvement. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection.  Resident files are stored securely. There are clear instructions provided to residents in their admission agreement on entry, regarding responsibilities of personal belonging. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Montecillo has a Māori health plan included in the cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Māori have this documented in their files, and care plans include interventions to meet their cultural needs. Linkages with Māori community groups are available and accessed as required. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents’ values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents’ needs are being met. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services of their choice. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | In the nine staff files sampled, job descriptions include responsibilities of the position and signed copies of all employment documents are included. Staff comply with confidentiality and the code of conduct. The RNs and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, the registered nurse and nurse aides confirmed an awareness of professional boundaries. Registered nurse files reviewed evidence attendance as professional boundaries and code of conduct training. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Montecillo policies and procedures meet the health and disability sector standards. Staff are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff report that the nurse manager and registered nurses are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RNs have access to external training. Discussions with residents and family were positive about the care they receive. |
| 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 (link 1.2.3.3). The nurse manager and registered nurses interviewed confirm that family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).  There is access to an interpreter service as 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 | Montecillo provides care for up to 44 rest home and hospital (geriatric and medical) level care residents. On the day of audit, there were 41 residents, which included 17 rest home, and 24 hospital residents. There were no residents under the medical component and one hospital resident on respite. All other residents were under the aged related contract. All rooms at Montecillo are dual purpose (rest home or hospital).  The service has a current strategic plan and a business plan for 2016. The business plan identifies the purpose, values and scope of the business. The quality and risk management plan outlines the quality goals, which are reviewed at the ethical and clinical advisory committee meeting and the heads of department meetings. The service is governed by a trust board, which has two divisions – a financial committee and the ethical and clinical advisory committee (ECAC). The ECAC meets two monthly and receives reports on all aspects of service delivery at Montecillo. The chief executive officer reports to the trust board meeting and the ECAC. A nurse manager provides clinical oversight at Montecillo.  The chief executive officer and the nurse manager have completed at least eight hours of professional development related to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The nurse manager provides cover in the absence of the chief executive officer, with support from the Montecillo office team and the registered nurses. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Montecillo is implementing a quality and risk management system. The chief executive officer and nurse manager oversee the quality programme. A consultant had been employed to conduct internal audits, and develop and review the quality and risk management programme. The quality programme includes goals for 2016. The previous year’s plan has been reviewed.  Policies and procedures implemented provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. However, the open disclosure policy does not fully align with service practice. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the InterRAI assessment tool.  The ethical and clinical advisory committee meeting, the heads of department committee meeting and the senior management team receive reports on the progress of the quality programme. Meeting minutes sighted evidenced discussion around accident/incident data, health and safety, infection control, audit outcomes, and complaints and concerns. A resident and relative survey was conducted in September 2015. Results have been collated but not analysed or reported back to residents or family. The service collates accident/incident and infection control data. Meeting minutes, monthly data comparisons, trends and graphs are available for staff information. The nurse aides interviewed were aware of quality data results, trends and corrective actions.  An internal audit programme covers all aspects of the service. The outcomes of internal audits are discussed with staff at the various meetings. Corrective actions have been developed and implemented for shortfalls in service identified.  There is an implemented health and safety programme in place including policies to guide practice. There are designated health and safety staff representatives. Current hazard registers have been developed for all service areas and are easily located for staff. Staff confirm they are kept informed on health and safety matters at meetings.  Fall prevention strategies are in place that include the analysis of falls incidents 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. | FA | Samples of accident/incident forms for April 2016 were reviewed. There has been RN notification and clinical assessment completed in a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family had been notified of accidents/incidents where this has been requested (link 1.2.3.3). Pressure injuries (current and previous) have been reported.  The service collects incident and accident data and reports aggregated figures to the ethical and clinical advisory committee, the clinical (RN) meeting, nurse aide meeting, health and safety meeting and heads of department meeting. Staff interviewed confirmed incident/accident data is discussed at the various meetings and information and graphs are made available.  Discussions with the management team confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health was notified of a recent outbreak. |
| 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. | FA | There are human resources policies to support recruitment practices. Eight staff files sampled contained all relevant employment documentation and included three registered nurses, three nurse aides, one activities coordinator and one cook. Current practising certificates were sighted for registered nurses and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that new staff were adequately orientated to the service on employment. Employment documentation was evident in the sample of staff files reviewed.  There is an education planner in place for 2016 and is being implemented. Three registered nurses have completed InterRAI training. Staff complete competencies relevant to their role. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The chief executive officer and the nurse manager are on-site full time and available after hours. The registered nurses are rostered on 24/7. The nurse aides, residents and family interviewed inform there are sufficient staff on duty at all times. Agency staff are used when required. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident’s individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant nurse aide or registered nurse including designation. Files are integrated. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There is a policy in place to guide resident admissions. Needs assessments are required prior to entry to the facility. There is an information pack provided to all residents and their families on services available. Residents and/or family are provided with associated information (eg, information on their rights, the Code, complaints management, advocacy, and the admission agreement). Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. The current version of the admission agreement aligns with the expectations in the aged residential care agreement and includes exclusions from the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has transfer and discharge policies and procedures in place. The procedures include the use of a transfer form to manage information during transfer and discharges. All residents transferred or discharged are noted on InterRAI by the registered nurse. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. When new medicines are supplied from the pharmacy, the RN completes a verification check against the resident’s medicine order. Medication orders include indications for use of ‘as needed’ medicines. Short life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities (medicine competencies for the registered nurse and caregivers were sighted). Administration sheets are appropriately signed. Fourteen (eight hospital and six rest home) medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was signed each time a medicine was administered by staff. One nurse aide and one registered nurse were observed administering medications and followed correct procedures. No residents self-administer medicines. Residents/relatives interviewed stated they are kept well informed of any changes to their medications. Not all medication charts had correct documentation by the GPs. |
| 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. | FA | There is a fully equipped commercial kitchen and all food is prepared and cooked on site. All kitchen staff have completed food safety training. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. The dietitian had reviewed the menu.  All fridges and freezer temperatures are recorded daily on the recording sheet. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room. A tray service is provided to the upstairs residents via a hotbox and to resident rooms as required. All food in the freezer and fridge is labelled and dated. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents’ dietary needs are communicated to the kitchen staff. Special diets can be catered for and currently the kitchen is catering for a resident who has a nut allergy. Alternative meals can be accommodated if needed. Residents’ weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented. There is a cleaning schedule in place. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a process for declining entry should this be necessary. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents would be recorded and communicated to the resident/family and alternative options suggested if appropriate. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An initial nursing assessment and initial care plan is completed within 24 hours of admission by the registered nurse (link 1.3.5.2). Personal needs, outcomes and goals of residents are identified. A range of assessment tools are completed on admission and reviewed six monthly or earlier if the resident’s health status changes. All residents have an InterRAI assessment in place. Assessment process and the outcomes are communicated to staff at shift handovers and through the clinical record. The assessment tools review links to the individual care plans, which include InterRAI outcome scores. The general practitioner completes a medical admission with two working days. All residents and relatives interviewed were satisfied with the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The initial care plan is developed in conjunction with the resident and family and includes needs as identified by the registered nurse, in consultation with staff. Not all initial care plans reviewed were fully completed.  Long-term care plans reviewed were individually developed with the resident and/or family. Residents and family members interviewed stated they were involved in the care planning process. Care plans reviewed were individualised for each resident, however not all interventions were documented as identified by the progress notes, assessments, GP notes and allied health reviews.  Activities care plans were completed for five of six long-term files reviewed (link to 1.3.7.1 for activity plans documentation). Residents are seen by the GP at least three monthly or more frequently if required. The GP records progress in the medical records and 3-month reviews are documented on the resident’s medicine management charts. Short-term care plans are in use. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Service delivery is guided by the resident’s plan of care, and handovers between shifts. Care plans are goal orientated and reviewed at six monthly intervals. The nurse aids and registered nurses interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights are monitored monthly or more frequently if necessary.  There are currently six residents with wounds, including one healing grade-two pressure injury and one resident with a chronic leg wound who was in hospital for treatment of this wound on the day of audit. All identified wounds had an assessment and management plan in place. There was evidence of input from the GP, the DHB vascular team and from district nurses. Short-term care plans for wounds did not all describe the short-term interventions needed by nurse aids (link 1.3.5.2).  Continence products are available, and specialist continence advice is available as needed. Nurse aids and RNs interviewed state there is adequate continence and wound care supplies.  Monitoring charts were well utilised and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required. Residents and family members interviewed confirmed their satisfaction with care delivery. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | There is one qualified diversional therapist (DT) employed who, with assistance from an activities assistant and staff, is responsible for the planning and delivery of the individual and group activities programme. Group activities are provided in the large communal rooms, in seating areas, and outdoors in the gardens when weather permits.  On the days of the audit, residents were observed being actively involved with a variety of activities including external entertainers. The group activities programme is developed monthly and a weekly plan is provided to all residents and posted on noticeboards. The group programme includes residents being involved within the community in social clubs, churches and schools.  Resident meetings take place three monthly, the meeting document resident feedback and follow-up of issues identified and a resident newsletter is provided every three months.  The DT interviews each newly admitted resident on or soon after admission and takes a social history. The diversional therapy plans for residents did not all reflect these assessments or the InterRAI assessment. Individual activity plans are reviewed three monthly and six monthly as part of the care plan review/evaluation process.  A record is kept of individual resident’s activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.  The service has its own van for transportation. Residents interviewed described van outings, musical entertainment and attendance at a variety of community events. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents are reassessed using the InterRAI process at least six monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The GP reviews residents three monthly or when requested if issues arise or their health status changes. The GP stated that the staff communicate appropriately. Short-term care plans reviewed had been completed for acute changes in health status. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to medical and non-medical services. The registered nurse interviewed confirms that residents, family and the resident’s GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the registered nurse. Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policies and procedures are in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and they are stored securely. Laundry and sluice rooms were locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practice. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness, which expires on 23 August 2016. The senior nurse aide/health and safety rep oversees the maintenance programme. Scheduled maintenance is carried out and staff records issues that require attention. Hot water temperature checks are conducted monthly and are between 40 and 45 degrees Celsius in resident areas. Medical equipment including scales and hoists have been checked and calibrated annually. Electrical equipment has been tested.  A small internal seating area at the entrance is available for residents and visitors. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. The exterior by the entrance is well maintained with safe paving, outdoor shaded seating, lawn, gardens, and car parking. Interviews with the registered nurses and the nurse aides confirmed that there was adequate equipment to carry out the cares according to the resident’s care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Resident rooms are all single rooms with full ensuites. There is a large communal lounge and dining area down stairs and smaller dining and lounge areas upstairs. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets are well signed and identifiable and include vacant/engaged and in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All residents have electric beds. Nurse aides interviewed report that rooms have sufficient space to allow cares to take place. Bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are two lounges and two dining rooms. The large downstairs dining and lounge area is used for activities, resident meetings and recreation activities. The downstairs dining room is spacious, and located directly off the kitchen/servery area. The residents who dine upstairs receive a tray service. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the designated laundry staff. Staff attend infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer’s safety data charts are available for reference if needed in an emergency. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | The service has an emergency and disaster manual. New Zealand Fire Service approved the evacuation scheme on 29 September 2006. Fire drills are conducted six monthly. Registered nurses are trained in basic life support but not first aid. Fire safety training has been provided. There is an electronic call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal areas and resident bedrooms have external windows with plenty of natural sunlight. A radiator system heats the facility, with individual heating in each resident’s room. On the days of audit, the general living areas and resident rooms were appropriately heated and ventilated. Residents and family interviewed state the environment is comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | A registered nurse is the infection control coordinator. The infection control coordinator’s job description has identified delegated responsibility for infection control within the service. The infection control coordinator provides a monthly report to management and staff. The infection control programme has been reviewed annually.  Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There was an outbreak in October 2015, which was reported to public health and was managed well.  The infection control team is included as part of the clinical team meetings. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator (registered nurse) manages infection control. The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required.  Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners. Systems in place are appropriate to the size and complexity of the facility.  Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, six monthly care plan reviews and GP reviews. Interviews with staff confirm their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had nine residents using restraint in the form of bedrails and/or lap belts and three residents with bedrails as an enabler. All enabler use is voluntary. One resident file of enabler use was reviewed. The enabler assessment form was completed and signed by the resident. This had been evaluated at least three monthly. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is a registered nurse and has a signed job description, and understands the role and her accountabilities. The policy and job description include clear responsibilities and accountabilities. All residents with a restraint in use are required to have an assessment and consent form and regular monitoring documented. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Suitably qualified and skilled staff, in partnership with the resident and their family, undertake assessments. A registered nurse is the restraint coordinator.  Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There was a restraint assessment tool completed for the four hospital resident files reviewed for residents requiring bedrails for safety. The care plan was up-to-date and included the risks and interventions associated with restraint use. Ongoing consultation with the resident and family was identified. InterRAI assessments identified risks and the need for restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.  The four hospital resident's files reviewed for residents with bedrail restraint, included specific interventions or strategies considered before use of restraint. The care plan reviewed identified observations, monitoring and family involvement. Restraint use is reviewed through the three monthly GP assessment, six monthly care plan evaluations, registered nurse meetings and the ethical clinical advisory group. A restraint register is in place, which has been completed for the nine residents requiring restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their care plan review. The family is included as part of the review. Evaluation timeframes are determined by risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The use of restraint is documented as reviewed and discussed at registered nurses’ meetings and the service ethical and clinical advisory group meetings. Discussion with staff evidences that the service actively reviews all restraint with attempts to minimise its use wherever possible. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  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. | PA Low | Policies and procedures have been developed, and are reviewed two yearly. Clinical policies align with best practice and guide staff in the safe delivery of care. The service has a system in place whereby new residents and relatives are asked about their preference regarding notifications of incidents and accidents. Relatives are offered choices in regards to the circumstances for notification. In the sample of resident files reviewed, the service has recorded when relatives wish to be informed. The service’s open disclosure policy and incident and accident policy does not align with this practice. | The procedure of recording when family are notified (eg, serious or major incidents only), is not included in the Montecillo open disclosure and accident and incident policy. The policies do not include a definition of what constitutes serious injury or major incident within the context of reporting to families. Advised that this is at the discretion of the registered nurse. | Review the open disclosure and incident and accident policy to ensure that it aligns with the service’s current notification practice, and that definitions are clearly recorded.  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 Low | Quality activities are conducted as part of the annual quality and risk management programme. Activities include internal audits, complaints process, meetings, and analysis of incidents and accidents. A resident and relative survey is conducted annually. The results for the 2015 surveys have been collated. Further analysis and feedback to residents and relatives has not been completed. | The resident and relative survey conducted in September 2015 has not been fully analysed and results have not been communicated to residents and families. | Conduct analysis of the latest annual survey and provide evidence that the outcomes are communicated to residents and family members.  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 | All fourteen medication-administration charts documented that all medication given was appropriately signed for. All regular medication, apart from insulin, was prescribed by the GP in a manner that meets legislative requirements. All ‘as required’ medications had an indication for use. Short-term medications did not all have start/stop dates and insulin prescribing did not include the times to be given. | Six hospital level and three rest home level medication charts had instances of the GP not documenting and signing a finish date for short-term medications. One rest home level medication chart had sliding scale insulin prescribed (given with meals) but there were no times or indications of when to give, other than how many times a day to be given. | Ensure that all medication charts meet legislative requirements.  30 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 Low | There are policies and procedures in place to guide staff around timeframes for resident assessment and care planning. Three of four hospital level residents had timely long-term care plans and two of three rest home residents had InterRAI assessments within set timeframes. | One hospital level resident did not have a documented InterRAI assessment within 21 days and one rest home resident did not have a long-term care plan documented within 21 days of admission. One hospital level resident with a pressure injury did not have a documented wound care assessment and plan until 20 days post-identification of the pressure injury. | Ensure that assessments and care plans are completed within the required timeframes.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All long-term resident files reviewed had a long-term care plan documented and had been reviewed and updated within the last six months. Interviews with nurse aids identified that they were aware of the care needs of the residents. Long-term care plans did not document all the care interventions needed for individual residents | (i) One hospital level resident did not have interventions for identified behaviours that challenge, care interventions for an excoriated skin as identified by the GP, and physiotherapist interventions were not reflected in to the care plan. (ii) One hospital level resident and one hospital respite resident with insulin medication did not have recognition and treatment of hypoglycaemia documented in the care plan. (iii) One rest home resident had an incomplete initial care plan and physio interventions were not reflected into the long-term care plan. (iv) One rest home resident did not have GP instructions reflected in the care plan. (v) One hospital respite resident did not have care of an indwelling catheter identified. (vi) One rest home resident with a suprapubic catheter did not have any interventions to ensure the entry site was cared for. | Ensure that care plans describe the care and support needed as identified by assessments, and reflect GP and allied health interventions.  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 | The DT interviews each newly admitted resident on or soon after admission and takes a social history. The diversional therapy plans for one rest home resident reflected the assessments or the InterRAI assessment. Group activity plans were in place and reflected the client group. Residents and families praised the activities provided. | Three hospital and one rest home level residents’ activities plan did not reflect the InterRAI assessment or the social history. One rest home resident did not have an individual activity plan documented. | Ensure that resident individual activity plans reflect the assessments and social history.  60 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | Emergency plans are in place to guide staff in the event of an emergency. Staff receive fire and evacuation training and six monthly fire drills are conducted. Registered nurses have current basic life support certificates – with training last conducted in February 2016. First aid training is not provided for staff. | There is not at least one staff member on duty with a current first aid certificate. | Provide evidence that there is at least one staff member on each shift with a current first aid certificate.  90 days |

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

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

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

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

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End of the report.