# Te Aroha & District Health Services Charitable Trust - Te Aroha & District Community 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:** Te Aroha & District Health Services Charitable Trust

**Premises audited:** Te Aroha & District Community Hospital

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

**Dates of audit:** Start date: 5 May 2016 End date: 6 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:** 39

# 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

Te Aroha and District Community Hospital is owned and operated by Te Aroha and Districts Health Services Charitable Trust. The service cares for up to 44 residents requiring hospital and rest home level care. On the day of the audit, there were 39 residents.

The service is overseen by a facility manager (non -clinical), who is qualified and experienced for the role. A clinical nurse manager supports the facility manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

This audit has identified the following areas requiring improvement. Cultural safety, informed consent, trending and analysis of quality data, corrective actions, health and safety, adverse event reporting, attendance at staff education, staff orientation, admission agreements, timeframes for InterRAI, care planning, interventions, care plan reviews, GP initial assessments, medication management, chemical safety, outstanding maintenance, access to call bells, restraint and linen storage.

## Consumer rights

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

The service complies with the Code of Health and Disability Consumers’ Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents’ rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## 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. |

Te Aroha and District Community Hospital is governed by a community trust and is managed by a facility manager and a clinical nurse manager/registered nurse. A 2016 quality and risk management plan is in place. This plan includes the vision, philosophy and values of the organisation. Strategic goals and objectives are documented and are regularly reviewed by the facility manager and the trust board. Quality activities are conducted, which generate improvements in practice and service delivery. Residents meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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

The facility manager takes primary responsibility for managing entry to the service, with assistance from the clinical nurse manager/registered nurse. Comprehensive service information is available. A registered nurse completes initial assessments, including InterRAI assessments. The registered nurses complete care plans and evaluations. Care plans are clearly written and healthcare assistants report they are easy to follow. Residents 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. Medicines are stored and managed appropriately in line with legislation and guidelines. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about 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 medium or high risk and/or unattained and of low risk. |

The building has a current warrant of fitness and emergency evacuation plan. There is a maintenance programme. Hot water temperatures are monitored. An adequate number of toilets, showers and hand basins are provided. All communal toilets and showers have distinguishable identification. There are five rooms with ensuites in the Lawrence block and two rooms with ensuites in the hospital. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the rest home and hospital. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. There were four residents with restraint and no residents with an enabler. Restraint management processes are in place.

## Infection prevention and control

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

Infection-control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are reported to relevant personnel in a timely manner.

## 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 | 31 | 0 | 14 | 5 | 0 | 0 |
| **Criteria** | 0 | 79 | 0 | 16 | 6 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure are being implemented. Discussions with care staff (three rest home and two hospital healthcare assistants, five registered nurses, and two activities coordinators) confirmed their familiarity with the Code. Interviews with seven residents (three rest home and four hospital) and ten relatives (four rest home and six hospital) confirmed that the services being provided are in line with the Code. The Code is discussed at resident and staff meetings. |
| 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. | PA Low | Informed consent processes are discussed with residents and families on admission. Written consents were not all signed correctly. The six (of seven) resident files reviewed for the residents admitted for long term and palliative care demonstrated that advanced directives are signed for separately. One of the seven files reviewed was for a respite palliative care resident. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All seven resident files sampled had a signed admission agreement signed on or before the day of admission and consents (link 1.3.1.4). |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Advocacy services are linked to the complaints process.  Interviews with staff, residents and relatives informed they were aware of advocacy and how to access an advocate. |
| 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 | Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents and relatives confirmed this and that visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Verbal and written complaints are documented. All complaints have noted investigation, timelines, corrective actions when required and resolutions. The complainant is asked to sign their name when they agree that their complaint has been resolved. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.  Four complaints were lodged in 2015. All four complaints were resolved. One complaint has been lodged in 2016 with the Health and Disability Commissioner (HDC) and was received by the facility manager on 1 April. This complaint, concerning a resident’s care, is currently under investigation. The facility manager has submitted all required documentation to HDC within the required timeframe and is awaiting their response. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters displaying the Code throughout the facility and leaflets are readily available. The service is able to provide information in different languages and/or in large print. Information is also given to next of kin/EPOA to read with the resident and discuss. On entry to the service, the facility manager and staff discuss aspects of consumer rights with the resident and the family/whānau, confirmed in interviews with the facility manager, care staff, residents, and relatives (link 1.1.10.4). |
| 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 | The service has policies that align with personal privacy and dignity. All staff are trained to respect residents’ rights. Staff were observed respecting residents’ privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met. Families interviewed confirmed that the residents are encouraged to be as independent as is safely possible. The resident satisfaction survey confirmed that residents who responded to the survey are called by their preferred name.  A policy describes spiritual care. All residents and relatives interviewed indicated that each resident’s spiritual needs are being met.  A policy on abuse/neglect is being implemented. There were no reports of abuse and/or neglect. |
| 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. | PA Low | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan.  Staff training includes cultural safety. Staff interviewed confirmed their understanding of the importance of whānau in the delivery of care for their Māori residents. One resident who identified as Māori was unable to be interviewed. The care plan for this resident did not identify any Māori cultural values and/or beliefs.  The service is able to access Māori advisors, which includes staff who identify as Māori. |
| 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 service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their individual values were being met.  Information gathered during assessment, including the residents’ cultural beliefs and values, is used to develop a care plan that the resident and/or their family/whānau are asked to consult on (link 1.1.4.3). |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct. Staff sign a ‘house rules’ document as part of the employment process. The RNs supervise staff to ensure professional practice is maintained in the service. All residents interviewed reported that the staff respected them. Job descriptions include the role and responsibilities of each position, which includes professional boundaries. The orientation and employment agreement provided to staff during their orientation includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that aligns with the health and disability services standards. Staff are required to attend orientation and in-service training (link 1.2.7.4 and 1.2.7.5). The resident satisfaction survey reflected high levels of satisfaction with the services provided. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of the principles of aged care and stated that they feel supported by the registered nurses.  A number of quality initiatives have been implemented over the past year including (but not limited to) enhancing communication pathways between management and staff, refining emergency procedures and implementing new health and safety processes to meet new legislative requirements. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the service and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs (link 1.2.4.3). Ten incidents/accident forms were viewed. The forms include a section to record family notification. All ten forms indicated family were informed. This is also documented in the family communication sheet that is held in the front of each resident’s file. Families interviewed confirmed they were notified of any changes in their family member’s health status.  Interpreter services are available through the DHB. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | A community trust board governs Te Aroha and District Community Hospital. The service provides rest home and hospital level care (geriatric and medical) for up to 44 residents.  The hospital and rest home service are delivered in separate buildings. The rest home service is delivered in the Lawrence building and the hospital service is delivered in the Te Aroha building. On the day of audit the rest home (Lawrence building) had 14 of 15 beds occupied. The hospital (Te Aroha building) had 29 beds of which 13 were dual purpose. There was one double room (occupied) and one 4 bedded room , all the rest were single.  There were 39 residents on the days of audit including 13 hospital level residents and 22 rest home level residents under the Aged Residential Care (ARC) contract, one hospital level resident under the young persons with disability (YPD) contract. There were also two residents under the DHBs primary care inpatient services (PCIS) contract; and one resident under the residential respite service contract for short-term palliative hospital level care. The service also holds a community day-programme contract, a long-term support of chronic conditions contract, and a transitional care services contract.  A 2016 quality and risk management plan is in place. This plan includes the vision, philosophy and values of the organisation. Strategic goals and objectives are documented and are regularly reviewed by the facility manager and the trust board.  The facility manager (FM) has undertaken a minimum of eight hours of professional development relating to the management of an aged care service in the past 12 months. The FM is supported by a clinical manager. |
| 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 | Roles and responsibilities are delegated to specific staff in the absence of the facility manager and in the absence of the clinical nurse manager. These responsibilities are documented, accessible to staff, are specific, and include the responsible staff member’s name and contact details. The facility manager and clinical nurse manager report that this has been an effective tool for delegating responsibilities to a variety of staff if one of them is absent. |
| 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 | A 2016 quality and risk management programme is in place. Interviews with management and staff reflect their understanding of the quality and risk management systems.  Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed (every two years). New policies or changes to policy are communicated to staff, evidenced in staff meeting minutes.  Adverse event data is collected, however, this data has not been trended or analysed. Internal audits are completed as per the internal audit schedule. Areas of non-compliance include establishing a corrective action plan however, this is not occurring in a consistent manner. The implementation of all corrective action plans was not evident.  Health and safety initiatives include a trained health and safety officer, and a health and safety committee that meets monthly. Hazard reporting is in place and a hazard register is maintained. Recent health and safety initiatives have included inducting all volunteers and external contractors to health and safety. The health and safety officer reports directly to the board. Two board members sit on the health and safety committee.  Falls prevention strategies include an investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Other strategies include sensor mats, and half-hourly checks on residents at risk of falling.  Improvement note: The service may wish to consider a review of the internal audit schedule to include an audit against the provider’s policies and procedures on the prevalence of pressure injuries and wound management. This would ensure that the service identifies any shortfalls and opportunities for improvements in these areas. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low | An accidents and incidents reporting policy is being implemented. Incidents and accidents are not trended or analysed and corrective actions are not fully completed for adverse events (link 1.2.3.6 and 1.2.3.8). Staff are informed regarding individual resident and staff adverse events during handovers and in staff meetings. There is evidence to support actions are undertaken to minimise the number of incidents. A registered nurse conducts clinical follow-up of residents. Unwitnessed falls with a suspected injury to the head include appropriate neurology observations. Not all incidents identified had a corresponding report form completed.  Discussions with the facility manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. A Section 31 report was completed appropriately for one adverse event. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resource management policies in place that include the recruitment and staff selection process.  Relevant checks are completed to validate the individual’s qualifications, experience and veracity.  Copies of current practising certificates are retained.  Seven staff files (one clinical nurse manager, two registered nurses, three healthcare assistants and one health and safety/quality and risk advisor) were reviewed and evidenced that reference checks are completed before employment is offered.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice.  The in-service education programme is being implemented.  Attendance at mandatory in-service training is frequently less than 50%.  Healthcare assistants are encouraged to complete an aged care education programme.  The nursing staff attend external training provided by the DHB.  Staff are appraised annually on their performance. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy describes staff rationale and skill mix.  The facility manager and clinical nurse manager are full-time employees Monday-Friday.  A minimum of one registered nurse is on site at any one time.  This is in addition to the full-time clinical nurse manager (Monday – Friday).  Adequate numbers of healthcare assistants are rostered in the hospital and the rest home although a concern was raised during interviews with the RN staff, healthcare assistants and the facility manager around inadequate healthcare assistant staffing levels when orientating new staff.  The facility manager reports that this concern is currently being investigated. Activities staff are available five days in the rest home and four days a week in the hospital. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident’s individual record within 24 hours of entry. Resident files are protected from unauthorised access. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant carer with the exception of three care documents that were not signed or dated. Residents’ files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| 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. | PA Low | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use does not align with the requirements of the ARC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. |
| 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 | Fourteen medication charts were reviewed and included eight hospital (including one resident admitted under a young person with disability, and one resident admitted under palliative care respite), four rest home, and two primary care inpatient residents. The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practices did not comply with the medication management policy on the medication rounds observed. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses and senior healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The registered nurse on duty reconciles the delivery and documents this. Not all medication charts reviewed aligned with prescribing requirements. There was evidence of three monthly medication reviews by the GP. Not all medication charts have photo identification. Allergies or nil known allergies were recorded. Two residents self-administering their own medicines did not comply with the organisations requirements for residents who are self-medicating. Standing orders are in use and comply with all contractual and legal requirements. |
| 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 | The service employs a qualified chef 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 this is 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 require special diets and the chef works closely with the registered nurses on duty. The kitchen staff have completed food safety training. The chef and cooks follow a rotating seasonal menu, which was reviewed in April 2016 by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| 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 records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The InterRAI assessment tool is implemented and there are three RNs competent to use the tool. InterRAI assessments have not been completed for all residents. Two of seven files sampled did not require a completed InterRAI assessment on the day of audit (one resident recently admitted and one resident admitted under the palliative care contract). Not all files sampled contained assessment tools that were fully completed and signed by a registered nurse (link 1.2.9.1). Not all assessments were reviewed at least six monthly or when there was a change to a resident’s health condition. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The long-term care plans reviewed described the support required to meet the resident’s goals and needs and identified allied health involvement under a comprehensive range of template headings (link 1.3.4.2). The InterRAI assessment and other assessments tools undertaken do not always inform the development of the resident’s care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Staff interviewed reported they found the long-term care plans easy to follow. Short-term care plans are not always documented for a change in health condition. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses and health care assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the registered nurse will initiate a referral (eg, to the district nurse, or wound specialist nurse). If external medical advice is required, this will be actioned by the GP.  Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit; however, the staff interviewed reported they did not always have access to sufficient dressings and syringes when they were required. Sufficient continence products are available and resident files include a continence assessment (link 1.3.4.2). Specialist continence advice is available as needed and this could be described.  On the day of audit, there were seven wounds. In the hospital there were five wounds including one lesion, two surgical wounds and two skin tears. In the rest home there were two wounds including one chronic ulcer and one lesion. There was one stage-two pressure injury (now resolved to stage one) in a rest home resident located in the hospital. Not all wound documentation was fully completed (link 1.3.5.2). All wounds have been reviewed in appropriate timeframes.  Interviews with registered nurses and healthcare assistant demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always demonstrate interventions to meet residents’ needs. Not all interventions in use were documented. Staff could describe the care required for the resident admitted under the young person with disability contract and the palliative care contract. There was evidence of pressure injury prevention interventions such as turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. The service has commenced a project around weight management for residents with initial results showing improved outcomes for residents with weight loss. |
| 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 | An activity programme is provided in both the rest home and hospital. The programme is developed by a diversional therapist in consultation with the designated activities coordinators in the rest home and hospital. The activities programme for the hospital and rest home were sighted. A number of volunteers support the programme. The activities programme is provided between Monday to Friday in the rest home and Monday to Thursday in the hospital. Residents and family interviewed confirm participation is voluntary.  Activities assessments and care plans are comprehensively documented however not all residents had a social/activities assessment completed on admission. Individual activities care plans and goals are developed. A record of individual attendance at activities is documented. Residents in both areas were partaking in activities during the audit. Not all residents had the activities care plan reviewed against the identified activities goals or within the required timeframes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were not all evaluated at least six monthly or earlier if there was a change in health status. Not all changes in health status were documented and followed up (link 1.3.5.2). Not all reassessments had been completed using InterRAI LTCF for all residents who had a significant change in health status since 1 July 2015 (link 1.3.4.2). The registered nurse completing the care plan signs the care plan reviews. (Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled link 1.3.5.2). |
| 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 other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Staff provided examples of where a resident’s condition had changed and the resident was referred for a change in care level. |
| 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. | PA Moderate | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly; however, these were not all stored safely throughout the facility. Safety data sheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | The building has a current building warrant of fitness that expires in September 2016. The Trust have made a significant investment in the past two years replacing carpet, redecorating Lawrence House, and purchasing new medical, kitchen and laundry equipment. The receptionist arranges the reactive maintenance with support from the facility manager. Not all reactive maintenance had been completed on the day of audit. There is an external contractor employed to undertake the scheduled maintenance. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans with exception (link 1.3.6.1). |
| 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 | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| 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 | The hospital has 23 single bedrooms (including one with an ensuite), one double room with an ensuite, and one four bedded room. There is one large lounge/dining area that is large enough to cater for group and individual activities.  Lawrence House (the rest home) is in a separate building and has all single rooms, of which three have an ensuite. There is a dining room and three other lounge areas. There is adequate space to allow for group and individual activities. |
| 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 | Dedicated cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.  The laundry service is contracted out and only small personal items are laundered on site. Residents interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | A fire evacuation plan is in place approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service checks all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff (link 1.2.7.4). Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.  There are call bells in the residents’ rooms, and lounge/dining room areas. Residents were not always observed to have their call bells in close proximity. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| 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. | PA Low | Te Aroha and District Community Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Not all infection control principles were being followed with the storage of the linen. A registered nurse is the designated infection control coordinator with support from all staff as the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| 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 | A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the GP and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| 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 | There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The newly appointed infection-control coordinator has completed the on-line Ministry of Health infection-control module. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors appropriate to their needs and this is documented in medical records. |
| 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 | Infection surveillance is an integral part of the infection control programme. Monthly infection data collected for all infections is based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually (link 1.2.3.6). The results are discussed at quality meetings. Reports are easily accessible to the registered nurses. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were four residents with restraint and no residents with an enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include the definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Staff education on RMSP/enablers has been provided. Restraint is discussed as part of staff meetings. A registered nurse is the designated restraint coordinator. |
| 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 | A restraint approval process is in place. The restraint coordinator role is delegated to a registered nurse. All staff are required to attend restraint minimisation training annually (link 1.2.7.5). |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family, and observations by staff. A restraint assessment tool is in place, which meets the requirements of the standard.  Two files of residents using restraints were reviewed and reflected appropriate assessments and consents with links to their care plans. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | A restraint register is in place. The register identifies four hospital-level residents using an approved restraint (wedge, lap belt, fallout chair). Restraint assessments reviewed identified that restraints are being used only as a last resort. As per the restraint minimisation policy, all restraints will be monitored a minimum of two-hourly. Monitoring documentation forms completed by staff did not reflect two-hourly monitoring while restraint was in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is reviewed three monthly by the restraint coordinator. Strategies are implemented to reduce restraint use. At the time of the audit, four hospital-level residents were using a restraint. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator and clinical nurse manager complete the restraint programme, including reviewing policies and procedures and staff education. The staff training programme on restraint minimisation includes de-escalation and is reviewed annually. |

# 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 1.1.10.4  The service is able to demonstrate that written consent is obtained where required. | PA Low | The registered nurse discusses the general consent form with the resident and or their EPOA at the time the resident is admitted. The registered nurse then ticks that they have discussed the general consents with the resident and or EPOA. The resident and or EPOA are not required to sign the general consent form to indicate they have or have not given consent. | Six of seven consent forms had not been signed by the resident or EPOA to indicate they have or have not given consent. | Ensure that the resident and/or EPOA sign the consent form.  60 days |
| Criterion 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs. | PA Low | As per policy, the facility manager and/or RN will determine the cultural and/or spiritual needs of each Māori resident in consultation with the resident, family and significant others as part of the admission process. This procedure was not documented for one resident who identifies as Māori. | One Māori resident did not have Māori values and beliefs documented in the resident file. | Ensure cultural values and beliefs are identified for Māori residents.  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 | The clinical nurse manager is responsible for collecting adverse event data and implementation of the internal audit programme, as per the internal audit schedule. Quality improvement data is collected around falls, skin tears, infections, and other adverse events, but there is little evidence to support that this data is being trended and analysed. Staff are informed regarding the number and type of adverse events each month but are not informed around trends in data or what the data is reflecting. Staff are informed of internal audit results, as evidenced in staff meeting minutes. | Quality data is not being trended and analysed. Staff are not kept informed regarding trends in adverse events. | Ensure that the quality data collected is trended and analysed, and that this information is shared with staff.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | A corrective action planning process is to be completed where internal audits reflect sub-optimal results. However, corrective action plans were not consistently being established when required. Where corrective action plans are developed, there are gaps in the documentation around implementation and sign-off of these corrective action plans. | i) Corrective action plans are not regularly being developed where opportunities for improvement are identified. ii) Where corrective action plans are documented, there is a lack of consistent evidence of these plans being implemented, with sign-off by the person(s) responsible. | i) Ensure corrective action plans are established where opportunities for improvements are identified. ii) Ensure that established corrective action plans are implemented and are signed-off by the person(s) responsible.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Ten accident and incident reports were reviewed. Each adverse event was documented in detail, and included a full investigation by a registered nurse and was signed off by the clinical nurse manager and the facility manager. A report form for a pressure injury was not completed. | One rest home resident with a stage-two pressure injury did not have an accident/incident form completed. | Ensure all pressure injuries are documented on an accident/incident form.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An in-service training programme is being implemented for staff and attendance records are being maintained. The frequency of mandatory training is dependent on the type of in-service and ranges from six months, one year, and two-yearly. Compulsory training includes continence management, nutrition/dietary, manual handling, pressure area care, pain management, rights/advocacy, wound management, and hoist training. | Staff attendance at eight mandatory in-services in 2015-2016 was less than 50%. The facility manager and clinical nurse manager are aware of this shortfall and they are implementing strategies to address it. | Ensure that all staff attend mandatory in-service training.  90 days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | When reviewing seven clinical records, it was noted that one continence assessment and two long-term care plans were not signed or dated, and not all wound care plans had been signed. All progress notes include the date and time of entry, and the signature and designation of staff. | i) One continence assessment and two long-term care plans were not signed or dated. ii) Six of seven wound care plans had not been signed by the registered nurse. | Ensure all residents’ assessments wound care plans and long-term care plans are signed and dated.  90 days |
| Criterion 1.3.1.4  Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Low | Residents and family/whānau confirmed on interview that they had received all relevant information on admission. The information pack contains information on the service, resident’s rights and advocacy brochure. Exclusions from the service are included in the admission agreement. The admission agreement in use does not comply with the requirements of the ARRC. | The amendments made in 2015 to clause D13.3 of the ARRC contract, regarding refund timeframes are not included in the admission agreement currently in use by the service. | Ensure that the current admission agreement aligns fully to the ARRC contract.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The registered nurses in the hospital and senior healthcare assistants in the rest home are responsible for the safe administration of medication. On the two medication rounds observed in the hospital the registered nurses did not follow the correct medication administration process. Ten of fourteen resident medication records had photo identification. All medication charts reviewed had allergies or nil known allergies documented. | i) Staff were observed administering medications without prior reference to the medication chart.  ii) Four of 14 medication charts (rest home) did not have photo identification on the medication profile. | i) Ensure that all staff who administer medication follow acceptable medication administration practices, guidelines and legislative guidelines.  ii) Ensure that all medication charts evidence resident photo identification.  60 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Residents who self-administer medication are required to complete a competency assessment every three months. The two residents self-medicating had not completed the required competencies. | Two rest home resident’s self-administering inhalers had not had the required competency assessment completed in the past 12 months. | Ensure that all residents self-administering medication complete the required competency assessments.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | The general practitioner prescribes all medication to be administered. Five of fourteen medications evidenced that indications for use were recorded for ‘as required’ medication. One medication did not have the route or dose time charted and this was corrected on the day of audit. | i) One of 14 medication charts reviewed did not have the route or dose time charted for a controlled drug. This was corrected on the day of audit.  ii) Nine of fourteen medication charts reviewed did not have indications for use charted for all ‘as required’ medication. | i) Ensure that all medication is prescribed according to all contractual and legal requirements.  ii) Ensure that all ‘as required’ medication has indications for use charted.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Registered nurse’s complete initial assessments and care plans within 24 hours of admission. Long-term care plans were completed within 21 days of admission. InterRAI assessments have been reviewed six monthly for two of seven residents. Two residents do not require the InterRAI assessment completed. | Three residents (one rest home, two hospital - including one young person with disability) had not had their InterRAI assessments reviewed six monthly. | Ensure that all aspects of assessments and care plans are completed within the required timeframes.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | The registered nurses interviewed stated that the registered nurses are responsible for completing the initial assessments (including InterRAI) and any other assessments required for a change in health condition. Not all resident files sampled had evidence that the required assessments had been completed. | i) One rest home resident admitted in August 2015 did not have an InterRAI assessment completed.  ii) One hospital resident had not had their InterRAI assessment reviewed with a change in health condition.  iii) Two rest home and one hospital residents with pain (as noted in the progress notes and medical notes) did not have pain assessments completed.  iv) One hospital resident did not have any risk assessments completed on admission.  v) Three residents (two hospital - including the hospital tracer, and one rest home) did not have the medical admission assessment fully documented.  vi) Four resident files sampled (two rest home and two hospital) had incomplete continence assessment forms.  vii) One rest home resident did not have the pressure injury risk reassessed following the development of a stage 2 pressure injury. | i-ii) Ensure that the use of the InterRAI tool complies with all contractual requirements.  iii) Ensure that pain assessments are completed for all residents reporting pain.  iv) Ensure that all required risk assessments are completed on admission.  v) Ensure that the medical admission assessments are fully documented.  vi) Ensure that all sections of additional risk assessment forms are completed.  vii) Ensure that residents are reassessed with a change in heath condition.  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 | The registered nurse is responsible for completing all necessary assessments and then using this information to document the care plan. In the files reviewed one resident had the long-term care plan documented before the assessments had been completed. The long-term care plan was not always updated following a change in care level and a care plan was not always documented for any acute changes in health condition. Wound assessment, monitoring and wound management plans are in place, however wound care documentation was not all fully completed. Nurses undertake a risk assessment for all residents however, interventions were not documented for all assessed care needs, and not all interventions in use had been documented in the care plan. | i) One hospital resident had their care plan completed before all the risk assessments had been completed.  ii) One rest home resident long-term care plan had not been amended following a change in assessed care level.  iii) Short-term care plans were not documented for one rest home resident with a urinary tract and a chest infection, and one hospital resident with a skin infection.  iv) Wound care documentation was not fully completed for the current wounds: a) five of seven initial wound assessments did not fully describe the wound; b) five of seven wound care plans did not document the progress of wound healing with each dressing change; c) four of seven wounds did not have a documented management plan.  v) Interventions had not been fully documented in the long-term care plan for;  a) One rest home resident identified as a frequent faller  b) One hospital resident, with severe depression and identified as a high risk of malnutrition  c) One hospital resident with a PEG feed and a urinary catheter  d) One rest home resident with visual impairment, a urinary catheter, and type II diabetes with unstable blood sugars  e) One palliative care resident with anxiety, a previous history of gastro intestinal bleeding, and had no end of life care plan documented  f) One rest home resident with a moderate risk of PI had no interventions documented in the long-term care plan to manage this risk  g) Two residents with nutrition supplements | i) Ensure that the assessment process is used to provide information to inform the care plan  ii) Ensure that the long-term care plan is reviewed following a change in care level  iii) Ensure that care plans are documented for all acute changes in health condition  iv) Ensure that all wound documentation is fully completed  v) Ensure that interventions are fully documented for all assessed care needs  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | There is a central ordering system in place for dressing and medical supplies. The registered nurses interviewed stated that they did not always have sufficient medical supplies for dressings or PEG feeding. | The registered nurses report that they do not consistently have sufficient clinical supplies including wound dressing supplies, or the correct syringes required for the resident on a PEG feed. | Ensure that there are adequate medical and dressing supplies to meet the assessed care needs of the resident.  90 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 diversional therapist completes the activities assessments and activities care plans in consultation with the resident or their family. Not all residents had an activities assessment or care plan completed on admission. The activities care plan is reviewed at least six monthly at the time the long-term care plan is reviewed. Not all activities care plans had been reviewed six monthly. | i) One hospital resident did not have an activities assessment completed on admission.  ii) Four of the five residents (two hospital, one YPD, one rest home) who were due for a six monthly activities care plan review had not had the activities care plan reviewed against the identified goals or a review completed six monthly. | i) Ensure that all residents have an activities assessment and activities care plan completed on admission.  ii) Ensure that the activities care plan is evaluated against the resident goals within the required timeframes.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | The registered nurses advised that they undertake a review of the long-term care plan at least six monthly; however, this was not always evidenced on the files reviewed. There was evidence in the medical notes that the GP assesses the resident with an acute change in health condition. . | i) Three of five (two rest home and one hospital) long-term care plans due for review not been reviewed six monthly. | i) Ensure that all long-term care plans are reviewed at least six monthly or when there is a change in health condition.  90 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Moderate | Chemicals are required to be stored safety however, it was noted during a tour of the facility that not all chemicals were kept in locked cupboards or in locked rooms. | i) Chemicals were found in unlocked cupboards under benches and on shelves in the hair salon, in resident toilets, in the flower room and in the ward kitchen.  ii) A dressing trolley being stored in an area the residents could access, had wound cleaning solutions (including betadine) left on the bottom shelf of the trolley. | i-ii) Ensure that all chemicals are stored securely.  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | The staff record reactive maintenance requests to be completed. Not all required maintenance had been completed on the day of audit. | The following shortfalls were identified around reactive maintenance;  i) In the hospital: a) the shower walls and ceilings have numerous areas where the paint is flaking, or chipped. b) One hospital shower has mould growing on the ceiling and has a crack in the lino-join in the corner of the shower. c) There are holes in the shower and toilet walls. d) There are swollen and exposed timber surfaces around the hand basins. e) The under-bench cupboards in the flower room and sluice room, have swollen timbers and cracked paint. f) There is rust showing through on a number of radiator heaters. g) The paint is chipped off on a number of door frames and bedroom doors exposing bare timber.  ii) In the main kitchen: a) The paint has rubbed off on the wall behind the food preparation sink exposing bare timber. b) The under bench cupboard doors have cracked and chipped paint.  iii) In Lawrence House: a) There is swollen and exposed timber surfaces around the hand basins. b) There are bare boards in the sluice room. | i-iii) Ensure that all outstanding maintenance is completed.  90 days |
| Criterion 1.4.7.5  An appropriate 'call system' is available to summon assistance when required. | PA Low | There is a call bell available for use. Residents were not always left with access to their call bells when staff were not in attendance. | On two separate occasions during the audit, six residents who could not mobilise were sitting in chairs in the hospital lounge/dining area with no staff in attendance and no ability to summon assistance or with access to call bells. | Ensure that residents always have access to their call bell or a method to summon assistance.  60 days |
| Criterion 3.1.1  The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management. | PA Low | There are documented infection control polices to guide safe practice however, not all the principles were being applied and linen was being stored incorrectly. | Towels and flannels were stored in a number of the communal bathrooms in the hospital and Lawrence block. | Ensure that all linen is stored correctly.  60 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Low | The clinical assessment for the use of restraint is covered in the restraint assessment and includes the frequency of monitoring residents while restraint is in use. As per policy, all restraint monitoring will be conducted two-hourly unless stated otherwise. Restraint monitoring forms that were being completed for the two residents did not reflect two hourly monitoring. The restraint coordinator reports that monitoring is taking place two-hourly or more frequently, but is not being documented. | Two-hourly monitoring of restraint use was not reflected on the restraint monitoring forms for the two residents’ files reviewed. | Ensure monitoring forms reflect documented evidence of restraint use being monitored.  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.