

The Rest Homes Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: The Rest Homes Limited

Premises audited: Makoha Rest Home

Services audited: Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory

Dates of audit: Start date: 8 August 2016 End date: 8 August 2016

Proposed changes to current services (if any): The service has been reconfigured as from 23 June 2016 to reduce rest home beds and increase dual purpose beds and further confirmation was sought as part of this audit. The proposed change will increase dual purpose beds from 9 to 20 and reduce rest home beds from 20 to 9. Residential disability beds remain at five and the total number of beds will remain at 34.

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

The Rest Homes Limited trading as Makora Rest Home and Hospital. It provides rest home and hospital level care for up to 34 residents and on the day of audit there were 26 residents. The service is managed by a clinical nurse manager who has resigned. The residents and relative interviewed all spoke positively about the care provided.

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

The audit was required to assess the preparedness of the service to increase the number of dual purpose beds from 9 to 20 and reduce rest home beds from 20 to 9.

The audit verified that there are appropriate processes and staffing levels to increase the number of dual purpose beds, although the recent resignation of the clinical nurse manager and the results of this audit should be considered in decisionmaking.

The service has addressed the three shortfalls from the previous certification audit around the documentation of 'as required' medicines, restraint management and the annual review of the infection prevention and control programme.

This surveillance audit identified that improvements are required in relation to human resource management practices, clinical assessments, the management of residents with pressure injuries, activities planning, care plan evaluations, medicines management and the servicing and where appropriate calibration of medical equipment and hoists.

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.
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The service communicates effectively with residents and provides an environment conducive to effective communication. There is a system in place for the management of consumer complaints. There have been no serious consumer complaints since the previous audit. Residents and a relative interviewed were aware of the consumer complaints process.

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.
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The service is managed by a registered nurse who was appointed to the role in May 2016 and has since resigned. She plans to finish employment on 9 September 2016. There is a business risk assessment and management plan in place, which includes the quality plan. The business operates a quality risk and management system which includes a range of policies, procedures and associated forms. The service contracts an external quality advisor who supplies all of the policies, associated procedures and

forms. There is a system in place for recording adverse events. Human resource management is overseen by the clinical nurse manager. . There were clearly documented and implemented processes which determine staffing levels and skill mix in order to provide safe service delivery, which considers the layout of the service. The clinical nurse manager is onsite five days a week, Monday to Friday. There is at least one registered nurse and at least one caregiver on duty at all times. The care staffing levels for the service meet the minimum requirements as specified in the aged residential care agreement. A number of human resource systems require improvement.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Service provision is coordinated to promote continuity of service delivery. The residents and a relative interviewed confirm their input into care planning and access to a range of life experiences and choices. Sampling of residents' clinical files validated service delivery to the residents. Resident's care planning is changed according to the needs of the resident when progress is different from expected. The service uses short-term care plans for acute problems.

The residents and a relative interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

A secure medicine dispensing system was in place. A review of staff competencies confirmed that not all staff have current medication management competencies. Eight residents were self-administering medicines according to policy. There is a

requirement for improvement relating to medicine competencies and the need for three monthly medicines reviews to be completed for all residents.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

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.
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The building has a current warrant of fitness. There have been no alterations to the building since the previous certification audit and no alterations were required to accommodate the reconfiguration of services. An improvement is required related to the servicing of the sitting scales, two hoists and medical equipment which were overdue for their annual servicing.

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.
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Restraint minimisation policy and procedures are congruent with the restraint minimisation and safe practice standard. Documentation of restraints and enablers includes identification of risks and monitoring timeframes. Definitions of restraint and

enabler use are congruent with legislation. There is a job description for the restraint coordinator and the service is maintaining a restraint register.

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 prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Staff are familiar with infection control measures and the use of personal protective equipment. The infection control surveillance programme is appropriate for the size and complexity of the services provided. Surveillance is completed at monthly intervals and contributes to the quality improvement within the facility.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	10	0	3	5	0	0
Criteria	0	35	0	2	8	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service operates a consumer complaints process that references Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The service had an up-to-date complaints register which identified the date of the complaint, the complainant, description of the issue and the actions taken.</p> <p>Consumer complaints received since the change of clinical nurse manager were reviewed. There was only one complaint, which related to standard of care and a staff member not answering a bell and was determined to be justified. There were no serious consumer complaints recorded.</p> <p>Residents and one family/whanau interviewed confirmed they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. Staff interviewed (which included the registered nurse, the enrolled nurse, a caregiver, the diversional therapist, the assistant cook, the facility manager, the clinical nurse manager) were aware of their responsibility to record and report any consumer complaints they may receive.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>The open disclosure policy identified that frank discussions with residents and their support person/family was required where relevant. Interpreters are available if required. There was evidence in records of adverse events that open communication was occurring and family were notified. Residents interviewed (which included two rest</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>home residents, one young person who was assessed as hospital level, one hospital level resident and one hospital level resident who was funded by the Accident Compensation Corporation) and the father of one of the hospital level residents reported that they were able to communicate their needs to staff.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Makora Rest Home and Hospital provides rest home and hospital level care for up to 34 residents. On the day of audit there were 26 residents, which consisted of Residential disability services – Intellectual -three rest home level and 1 hospital level; Hospital services - Medical services- none ; Hospital services - Geriatric services (excl. psychogeriatric) -5 (which included 1 in hospital); Rest home care (excluding dementia care) 17; Residential disability services – Physical -none; Residential disability services – Sensory-none.</p> <p>There is a business risk assessment and management plan in place which includes the quality plan. It contains the purpose, values, scope, and direction. The goals of the organisation are clearly identified and the plan includes objectives and who is responsible. The plan is being reviewed currently with the appointment of the new clinical nurse manager.</p> <p>The business maintains agreements with Lakes District Health Board (for aged related residential care and long term support chronic health conditions) and the Ministry of Health for residential-non aged (ie, Younger aged care facilities YPD- Hospital).</p> <p>The Ministry of Health approved a recent reconfiguration of the business as from 23 June 2016 to reduce rest home beds and increase dual purpose beds and sought further clarification from this audit. The reconfiguration will increase dual service beds from 9 to 20 and reduce rest home beds from 20 to nine. Residential disability beds will remain at five and the total number of beds will remain at 34.</p> <p>The service is managed by the clinical nurse manager who was appointed to the role in May 2016 and has since resigned. She tendered her resignation on 6th August and plans to finish employment on 9 September 2016. She is a registered nurse and has worked in aged care positions with District Health Boards for many years. She has a postgraduate certificate in rehabilitation. She is a suitably experienced and qualified manager. She is supported by a facility manager who has been in the role since September 2015. The clinical nurse manager reports to the owner who is a psychogeriatrician. The clinical nurse manager maintains her eight hours professional development per annum. She is a member of the NZ Nurses Organisation gerontology section.</p>
<p>Standard 1.2.3:</p>	<p>FA</p>	<p>The business operates a quality risk and management system which includes a range of policies, procedures and</p>

<p>Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>associated forms. The quality and risk management system includes consumer satisfaction with clinical care and environmental systems and processes, internal audit, human resource management, adverse event management, health and safety, restraint minimisation practices and infection prevention and control systems.</p> <p>There are a range of policies and procedures in place that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by the quality plan which requires that documents are reviewed bi-annually or earlier. The policies include reference to interRAI LTCF assessments.</p> <p>There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures were accessible by staff. The master copy is held by the clinical nurse manager and hard copies are made available for staff. The service contracts an external quality advisor who supplies all of the policies, associated procedures and forms.</p> <p>Key components of service delivery were linked to the quality management system. The quality and risk management system is linked with the health and safety, complaints management and infection prevention and control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery.</p> <p>Data are collated and analysed and discussed at management meeting that staff are invited to attend. The management meeting happens monthly. It has a set agenda which includes quality and risk management.</p> <p>Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process and the management meeting. Corrective actions are documented on the internal audit forms and document the non-conformance, proposed actions and required quality improvement recommendations. When these are implemented the corrective actions are signed off as completed.</p> <p>Actual and potential risks were identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted included the identified risks, how these are monitored, if the risk is a significant risk and if the implemented actions can isolate, eliminate or minimise the risk. The hazard register is maintained for each area of the service.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	<p>FA</p>	<p>The service had clearly documented and known processes for reporting, recording, investigating and reviewing adverse events. A review of incident/accident records and analysis and interview with the business and quality manager confirmed that all events were reported, recorded and reviewed by the manager, as soon as possible.</p> <p>The clinical nurse manager understands the responsibilities for essential notification to the relevant authorities. The</p>

<p>unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>service has had not had to report any adverse events to external agencies.</p>
<p>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.</p>	<p>PA Low</p>	<p>Human resources policies described good employment practices that meet the requirements of legislation. However the review of a sample of employee records which was stratified to include two registered nurses (RNs), one enrolled nurse (EN), one care giver, and one cook).demonstrated discrepancies in practice. Four of the five employees had an employment agreement on site except for one registered nurse where there was no evidence of an employment agreement on record. The other registered nurse had an employment agreement that was dated 12 October 2016, which was clearly an error. There was no evidence of Police vetting for one RN who had been employed since the previous audit. There was no evidence of appraisals for the two registered nurses and one enrolled nurse. The other caregiver and the cook were recent employees employed within the last year and were not due for performance appraisals. Professional qualifications are validated, including evidence of registration and scope of practice for registered health practitioners. The clinical nurse manager validates all staff that require practising certificates annually, which includes the house general practitioner and the physiotherapist. New staff received an orientation/induction programme that covers the essential components of the service provided. The service employs 24 hour registered nurse cover and engages an agency staff or the clinical nurse manager provides onsite cover. There is a house doctor who visits every week and is on call to visit as needed. The service contracts a physiotherapist who is currently visiting weekly. The physiotherapy hours are expected to increase as the number of hospital level residents' increase. The service contracts a podiatrist who visits every six weeks or earlier if needed. The service accesses allied health specialists through referral to the DHB's community service team as needed. The service encourages care givers to achieve NZQA qualifications. The clinical nurse manager is in the process of determining which care givers have achieved what qualifications. In addition to promoting Careerforce training, a training plan is maintained to ensure regular staff education occurs. Impromptu training occurs as required usually in relation to an adverse event. Records of attendance are maintained. Registered nurses are supported to maintain their registration, which is discussed at performance appraisal time. The service lacks registered nurses who are interRAI trained and there are plans for RNs to complete interRAI training in place.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There were clearly documented and implemented processes that determine staffing levels and skill mix in order to provide safe service delivery, which considers the layout of the service. The clinical nurse manager (RN) is onsite five days a week, Monday to Friday. There is at least one RN on duty at all times and one or more caregivers (confirmed by observation, review of the roster and in discussions with staff and residents). The care staffing levels for the service meet the minimum requirements as specified in the aged residential care agreement.</p> <p>The caregivers assist the cleaner with cleaning duties. A person is employed is to clean five days a week from 9 am to 5pm and on occasions the weekends if needed..</p> <p>The caregivers do the laundry. The clinical nurse manager reports that as resident numbers requiring hospital level of care increases the intention is to employ a dedicated laundry person.</p> <p>There were sufficient kitchen staff to meet the needs of the reconfigured service.</p> <p>The clinical manager intends to increase the number of hours of activities staff to meet the needs of the residents in the near future as currently the service employs a diversional therapist four hours a week and care givers provide the individual and group activities programme (link 1.3.7.1).</p> <p>The residents and the relative interviewed reported satisfaction with the skills of the staff and the care provided.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Medication areas, including storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Weekly checks and six monthly physical stock takes occur. The medication refrigerator temperatures are not recorded.</p> <p>Current medication competencies for staff who administer medicines were sighted however these have not been completed annually for three of six registered nurses who administer medicines. The medication round was observed and evidenced the staff member was knowledgeable about the medicines administered however administration of medication was not signed off as the dose was administered. Administration records are maintained, as are specimen signatures.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There are four residents self-administering medicines at the facility and this was conducted according to policy. All have an assessment to determine competency. Each resident is able to store their medicines in their room and all rooms are locked when the resident is not in the room.</p> <p>Six of the twelve medication files reviewed indicate that the general practitioner reviews the medications as directed and at least three monthly. Eye drops and nasal sprays were not dated when opened. There is a refrigerator in the nurses' station to keep medicines in. The temperature of the refrigerator is not monitored.</p> <p>Four residents self-administer medicines and there are processes in place that keep residents safe. All have a</p>

		<p>locked room or area to store medication and this is checked by the staff on duty on a daily basis.</p> <p>Indications for use are documented for as required medications and the previous requirement has been met.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>Interview with the assistant cook confirmed kitchen staff have completed food safety training, and this was verified by food safety certificates. The assistant cook confirmed that they were aware of the residents' individual dietary needs and nutritional profiles are kept in the kitchen. These are not updated on a six monthly basis or as changes occur (refer to criterion 1.3.3.3) however the cooks put any changes on the white board as residents identify food they dislike.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided.</p> <p>The kitchen environment is mostly clean, well-lit and uncluttered however there is a requirement to clean behind appliances. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures.</p> <p>There is a seasonal menu, last reviewed by a dietitian in August 2015. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available.</p> <p>There was enough stock to last in an emergency situations for three days for all residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>The residents' care plans do not consistently evidence the required interventions as some care plans are not reviewed or documented as changes have occurred.</p> <p>Two residents with pressure injuries were reviewed. All pressure injuries are dressed by the district nurses and the service does not receive a copy of the plans. The registered nurses state that they dress pressure injuries as per district nurse's verbal handovers.</p> <p>The general practitioner documentation and records are current (refer to criterion 1.3.12.1). In interviews, residents and family confirm their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files in progress notes. The general practitioner states that staff provide care as per the resident's needs for the residents that they review.</p> <p>Care staff document progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</p> <p>Short-term care plans are used to document short term episodes that arise for residents. These were sighted in</p>

		<p>resident files and include short term cares for infections, wounds and a headache. Evidence of resolution of the issue was documented.</p> <p>Behavioural plans are documented for residents who have challenging behaviours (refer 1.3.3.3 and 1.3.8.1).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>The service employs a diversional therapist (DT) for four hours a week. There is a volunteer who works for two hours with the diversional therapist. In interview with the DT, they confirmed the activities programme is available to all residents in the rest home and the hospital, and state that there are some activities for young people. The group programme is documented on a monthly basis and displayed in the dining area. The activities programme includes a range of activities such as outings and cognitive activities and supports celebrations for residents.</p> <p>There are activities assessments and activities care plans in some resident files reviewed however these are not completed by the resident and are not individualised. They also are written from a staff perspective. One resident stated that they wanted to go out but there were no staff available to support them to access the community. A number of other residents access the community independently.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Timeframes in relation to care planning evaluations are documented. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans were sighted in some of the residents' files, and these are used when required. The family are notified of any changes in resident's condition, confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>PA Low</p>	<p>The building warrant of fitness expires 24 May 2017. There has been no reconfiguration of the building since the previous audit.</p> <p>The increase in dual purpose beds has not required any structural changes to the rooms. The remaining rest home rooms are of sufficient size to accommodate hospital level residents. There are two lounges and large dining room/activities. Each of the new dual purpose rooms and ensuites can accommodate a hoist and other equipment in the room. All dual purpose rooms are a standard size and have shared ensuites. There is an electronic call bell system in place.</p> <p>There are two hoists on site for generic use which include a standing and sling hoist. There are other hoists that</p>

<p>for their purpose.</p>		<p>have been supplied for personal use which are serviced by the providers. The service has recently purchase a stand turner which is proving to be easier to use for residents and staff. The service owns sitting scales. The sitting scales, medical equipment and the two generic hoists have not been recalibrated or serviced in the past 12 months and a contractor has been arranged on the day of audit to service this equipment next week. The service leases pressure area mattresses and other equipment as needed.</p> <p>The service has a planned and reactionary maintenance programme and the clinical nurse manager is in the process of making refurbishment changes.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>The infection prevention and control policy describes the expectations for the annual review of the infection prevention and control programme. The annual review was sighted for 2015. The previous requirement identified at certification has been met. The responsibility for infection prevention and control lies with the clinical nurse manager. There are systems in place to protect residents and staff from exposure to infection.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet. Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and health and safety meetings.</p> <p>The clinical nurse manager is delegated as being the infection control nurse. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events. Infection summary logs are maintained for infection events in individual resident's files reviewed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. Restraint and enabler use are documented in residents' care plans. There is a job description for the position of the restraint coordinator. The restraint register is maintained. The service has no restraints in use on the day of audit and has three residents using a lap and or chest belt as an enabler. Documentation for one resident using an enabler indicates that the service monitors the enabler when in use as the resident is not always able to tell staff if there are issues with the belt. They are however able to give consent for the enabler.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>Staff are able to describe the policy around restraint. Staff have had training around use of restraint in the past year. The previous requirement identified at certification has been met. The responsibility for the restraint process is delegated to the registered nurse who works with the general practitioner, family and resident to approve any use of restraint. There is no restraint used in the facility on the day of audit.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is a system to ensure staff receive education. The service encourages care givers to achieve NZQA qualifications. It has a training schedule in place and impromptu training is provided. There is a system of human resource management in place. A review of a sample of five employment records showed shortfalls in employment practices.</p>	<p>One registered nurse’s employment records contained no evidence of an employment agreement. The second registered nurse had an employment agreement that was dated 12 October 2016, which was clearly an error. There was no evidence of Police vetting for one registered nurse who had been employed since the previous audit. There was no evidence of appraisals for the two registered nurses and one enrolled nurse. The other caregiver and the cook were recent employees employed within the last year and were not due for</p>	<p>Ensure employment practices conform to policy to ensure safe and effective services to residents.</p> <p>30 days</p>

			performance appraisals.	
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medicines management processes are documented in policy. The system promotes safe and appropriate dispensing, administration, review, storage, disposal and reconciliation. Three monthly reviews were not consistently completed. All 10 files reviewed indicated that the medicine review had been completed in the last three months as per the general practitioner documentation.</p> <p>The controlled drug register indicates that the controlled drugs are checked out by two staff members (one is a registered nurse) with both staff signing the register. One staff member signs the administration sheet.</p> <p>The registered nurse was observed to give medication to residents. The registered nurse takes a group of medicines for a number of residents in a container and signs for these once all are given.</p>	<p>Four of the ten medication files reviewed did not have medicines reviews completed in a timely manner as per the general practitioner documentation.</p> <p>The administration record in the resident file is not consistently signed by two staff when a controlled drug is administered.</p> <p>Drops and sprays are not dated when they are opened and it is not possible to determine if these still viable.</p> <p>There is a refrigerator to keep medicines in in the medication room/nurses station. Temperatures are not recorded.</p>	<p>Ensure that medicines are reviewed by the general practitioner as per their documentation of review.</p> <p>Ensure that the administration sheet is signed by two staff when a controlled drug is administered.</p> <p>Date each drop/sprays such as eye drops or nasal sprays as directed when opened.</p> <p>Monitor the temperature of the refrigerator that is used to keep medicines in.</p> <p>30 days</p>

<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>There is a process to complete medication competencies annually however these have not been completed in a timely manner for three of six registered nurses who administer medicines.</p>	<p>Medication competencies are not reviewed annually by a registered nurse who has been assessed as competent for all registered nurses who administer medicines.</p> <p>The registered nurses do not consistently sign for the medication administration at the time the medication is given to an individual resident.</p>	<p>Review medication competencies annually.</p> <p>Ensure that the registered nurse signs for the medicines as these are administered for each individual resident.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>The kitchen is cleaned by the cooks. Main areas and surfaces are kept clean. Some areas of the kitchen floor are not clean e.g. flooring behind appliances and under benches at the back. The cooks monitor the temperatures of the chiller and chest freezer with the chiller kept at an appropriate temperature. The cook is able to describe the correct temperatures of the chiller and freezer. The freezer temperature was recorded at 10 degrees Celsius six days prior to the audit however there was no indication that a corrective action plan had been put in place. The cook stated that the freezer temperature had not been consistently maintained with the normal range since that time. The ice-cream in the freezer appeared to have been refrozen and another packet of food felt soft and not completely frozen. When the issue was identified on the day of audit, the clinical nurse manager directed that all food be thrown out and this was completed prior to the auditors leaving the premises.</p>	<p>The kitchen floor is not consistently cleaned.</p> <p>The freezer temperature was not recorded as being within normal range and food appeared soft or refrozen on the audit day. This was initially identified as a high risk as a corrective action plan had not been put in place when a high temperature had been identified however the clinical nurse manager addressed the issue on the day of audit.</p>	<p>Clean all flooring in the kitchen on a regular basis.</p> <p>Monitor the temperatures of the chiller and freezer as directed in the policy and put a corrective action plan in place immediately if the temperature is recorded as out of the normal range.</p>

				30 days
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>Files for two residents who had recently been admitted to the service were reviewed. One should have had an initial assessment and care plan completed and the other should have had an initial care plan and initial long-term care plan completed as per timeframes documented in the ARC contract and in the policy manual.</p> <p>Three files had a documented consent form on file.</p>	<p>Initial assessments and initial care plans including the initial long-term care plan are not completed in a timely manner.</p> <p>Specialised assessments are not reviewed six monthly or as changes occur and the care plans are not updated in response to the assessments completed.</p> <p>Three of the resident files did not have a consent form completed.</p> <p>Initial medical assessments are not always completed by general practitioners (GP) within required timeframes.</p>	<p>Complete initial assessments and care plans as per the ARC contract and the policy manual.</p> <p>Ensure that each assessment is reviewed six monthly or as changes occur and ensure that the care plans are updated in response to the assessment process.</p> <p>Ensure that each resident signs a consent form.</p> <p>Ensure that initial medical assessments are completed by general practitioners within required</p>

				timeframes. 90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>District nursing services are designated as dressing all pressure injuries. They document and retain any documentation related to the wound. The long term care plan references the pressure injuries. registered nurses are responsible for dressing the pressure injuries in the weekend for some and as required.</p> <p>One other resident has a two wounds. Both are dressed by the registered nurses at the service. There is an assessment and short term care plan for both of the wounds.</p> <p>Interventions are documented in the long term care plans and in short term plans however these do not always reflect up to date and current interventions required by the resident or relevant interventions as per the age of the resident.</p>	<p>Management plans for pressure injuries are not kept at the service.</p> <p>Interventions that reflect the current needs of residents are not consistently documented.</p>	<p>Keep copies of the district nursing management plans for pressure injuries at the service to inform staff who are monitoring the wound and changing dressing as required.</p> <p>Consistently document interventions that reflect the current needs of residents.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources,</p>	<p>PA Moderate</p>	<p>The diversional therapist works only four hours a week. There is insufficient evidence to demonstrate that activities are planned and provided/facilitated to develop and maintain strengths including activities for residents under the age of 65 years. Some younger residents attend day programmes in the community. The group programme does not include activities for young people or one to one activities for those who do not</p>	<p>There are insufficient hours allocated to the activities programme. Activities are not scheduled or planned for residents under the age of 65 years or for one to one activities for those who cannot or chose not to engage in</p>	<p>i) Provide an group activities programme that supports all residents with a range of</p>

<p>and interests) that are meaningful to the consumer.</p>		<p>wish to engage in group programmes.</p>	<p>group activities.</p>	<p>activities included.</p> <p>ii) Sched ule/plan activities for residents under the age of 65 years and/or one to one activities for those who cannot or chose not to engage in group activities.</p> <p>90 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Evaluations are expected to be completed six monthly. The evaluations had not been completed in the four of four files where this was indicated.</p>	<p>Evaluations for four of the four files where an evaluation of care was indicated had not been completed six monthly.</p> <p>The evaluation of care was not current in two of the four files reviewed.</p> <p>The care plan is not always reviewed when the assessments have been completed.</p>	<p>i) Ensur e that an evaluations of the care plan is completed six monthly.</p> <p>ii) Ensur e that each care plan has a current evaluation of care (i.e. within the last six months).</p>

				<p>Ensure that the assessment process is used to inform the care planning process.</p> <p>90 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>The registered nurse is able to describe updating of care plans as changes occur. The general practitioner states that the staff respond to changes in care.</p>	<p>There are a number of examples in care plans where the plan has not been updated in response to changes in care.</p>	<p>Ensure that care plans are updated as changes are identified.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There are two hoists on site for generic use, which include a standing and sling hoist. The service uses a set of sitting scales to weigh residents. A number of residents have their own hoists. The sitting scales, medical equipment and two generic hoists had not been recalibrated or serviced in the past 12 months. The facility manager was unaware of the requirement and on the day of audit made arrangements for servicing to occur the week following the audit.</p>	<p>The sitting scales, medical equipment and two generic hoists had not been recalibrated or serviced in the past 12 months. The facility manager was unaware of the requirement and made arrangements for servicing to occur the week following the audit.</p>	<p>Ensure sitting scales, medical equipment and hoists are serviced and where appropriate calibrated annually.</p> <p>30 days</p>

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

No data to display

End of the report.