# Tainui Home Trust Board

## 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 The DAA Group 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:** Tainui Home Trust Board

**Premises audited:** Tainui Resthome

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

**Dates of audit:** Start date: 13 October 2016 End date: 13 October 2016

**Proposed changes to current services (if any):** The Ministry of Health has approved two applications since the previous audit to increase the total beds numbers from 58 to 60 and has requested specific reference to this.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 57

# 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

Tainui Rest Home provides residential care for up to 60 residents who require hospital and rest home level care. On the day of audit there were 57 beds occupied. The facility is operated by Tainui Home Trust Board.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The areas that required improvement from the previous audit relating to a quality plan, informed consent policy, GP reviews, and timeframes for developing care plans following admission have been addressed. The resuscitation policy, resident records being legible and/or service provider’s name identifiable, resident documentation, including support and intervention in the care plans, evaluation of care plans, restraint assessments and quality reviews of restraint remain open.

There are new areas requiring improvement from this audit relating to holding regular staff meetings; quality data being analysed to identify trends; developing corrective actions and reporting back to staff; interRAI assessments not completed in required timeframes and insufficient detail in care plans to guide staff; updating of care plans and development of short term care plans when a resident’s health status alters; food in the chiller/freezer not consistently labelled or dated; individual evaluation of restraint not meeting the standard; a high number of residents assessed as hospital level care using restraint and lack of privacy for one resident in the bedroom that is now providing double accommodation.

## Consumer rights

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

Information regarding residents’ rights, access to interpreter services and how to lodge a complaint was available to residents and their families. The complaints register is current and all complaints have been entered. Residents and their families reported their satisfaction with the open communication with staff.

One investigation has been completed by District Health Board since the previous audit. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## Organisational management

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

Tainui Home Trust Board is the governing body and is responsible for the service provided. A business plan includes a mission statement, values, quality objectives, strengths and weaknesses.

The facility is managed by a chief executive officer who has experience working in the aged-care sector. The chief executive officer is supported by a clinical manager who is responsible for oversight of the clinical care provided to residents.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented and monitored for effectiveness following deficits identified in internal audits. Registered and enrolled nurses’ meetings and health and safety meetings are held on a regular basis and there is reporting of numbers of various clinical indicators.

Policies, apart from the resuscitation policy, cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff reported they are updated on new policies or changes to policies.

The risk register evidenced review and updating of risks and the addition of new risks. The quality manager is aware of and has attended training in the Health and Safety at Work Act (2015) requirements and has implemented requirements.

Human resources processes are followed. There are policies and procedures on human resources management. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practise. Registered nurses are rostered on duty at all times. The clinical manager, a senior registered nurse and chief executive officer are on call after hours.

## Continuum of service delivery

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

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff (including a physiotherapist and pharmacist), a range of visiting health professionals such as clinical nurse specialists as well as the residents’ general practitioner. On call arrangements for support from senior staff are in place. Verbal and written shift handovers, ‘wing’ diaries and the regular updating of resident progress notes guide continuity of care.

Care plans are individualised, based on a range of clinical information. All residents’ files reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by two qualified diversional therapists, with additional support from volunteers. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic medication management system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and with one exception met food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

A current building warrant of fitness is displayed. The total bed numbers have increased by two since the last audit. The chapel prayer room is able to be converted into a bedroom and a large bedroom is now providing double accommodation.

## Restraint minimisation and safe practice

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

Policies and procedures for restraint minimisation and safe practice are in place. There are currently 13 residents using restraint and two residents using an enabler.

## Infection prevention and control

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

Aged care specific infection surveillance data is analysed and trended across the facility. Results are reported to the General Manager and to the Board, as well as being reported to staff. Follow-up action is taken as and when required.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 11 | 0 | 7 | 4 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 8 | 5 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

|  |  |  |
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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| 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 | The service has redeveloped its resuscitation policy since the previous audit visit. The policy now includes information on roles and responsibilities in relation to resuscitation, but still not in relation to advance directives. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility.  The complaints register reviewed showed that seven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible.  The chief executive officer (CEO) is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.  There has been one complaint investigated by the local DHB since the last audit concerning a potential resident admission. This complaint has been investigated and documentation evidenced it has been closed out. The CEO reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Resident records included evidence of open disclosure and timely communication with residents/families. Communication was documented in family communication sheets, on accident/incident forms as well as the detailed documentation in the residents’ progress notes. Family members stated they were informed in a timely manner about any changes to the resident’s status and appreciated the ongoing communication with staff. Evidence was sighted of both families, and where possible, residents, having input into the care planning process, and of family input into the multidisciplinary residents’ reviews. Staff were observed communication effectively with residents and family. Interpreter services are able to be accessed from the local District Health Board when required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The current business plan includes a philosophy, mission statement, goals, objectives, a business structure and an organisational flow chart and reporting lines. The CEO and senior management team provide two monthly reports against the objectives to the trust board. A sample of reports reviewed showed adequate information to monitor performance is reported including financial performance, clinical indicators, and emerging risks and issues.  The service is managed by a CEO who is a registered nurse and holds relevant qualifications including a management degree. The CEO has been in the role for three and a half years. They are suitably skilled and experienced for the role and have responsibilities and accountabilities defined in a job description and in their individual employment agreement. The CEO confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending conferences and forums held at the local DHB. The CEO is supported by a clinical manager and a quality manager.  Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.  Tainui Home is certified to provide hospital and rest home level care. On the day of audit there were 14 hospital residents and 43 rest home residents residing in the facility. The CEO reported all bedrooms have been approved by the Ministry of Health as dual purpose bedrooms providing either hospital or rest home level care.  The service holds contracts with DHB for enhanced intermediate care, aged related residential care, residential respite services, and long term support chronic conditions. |
| 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 quality and risk management plan was developed following a ‘SWOT’ analysis completed in 2015. This is used to guide the quality programme and includes strategies, core indicators, quality goals and actions. The quality policy has also been reviewed and expanded since the last audit. This finding from the previous audit has been addressed. There was evidence that quality improvement data is collected and collated. Data consists mainly of numbers and graphs. There is some analysis of data, however, this is inconsistent and basic and any trends are not identified. Corrective actions are developed and implemented to improve service delivery following completion of internal audits and health and safety meetings. There was no evidence of corrective actions following the resident/relative surveys and meeting minutes for staff and RNs/ENs do not document timeframes and sign off. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed.  Health and safety, RN/EN and resident meetings are held on a regular basis. The meeting minutes evidenced reporting of numbers of collated clinical indicators including falls, skin tears and infections. There was no evidence of reporting and discussion of any analysis to identify trends. One only general staff meeting has been held this year. The CEO and staff confirmed this.  Policies and procedures, apart from the resuscitation policy, are current and relevant to the scope and complexity of the service (refer criterion 1.1.10.7). They reflect current accepted good practice and reference legislative requirements. Care staff confirmed the policies and procedures provide appropriate guidance and that they are advised of new policies / revised policies by the quality manager.  A hazard register identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A health and safety manual includes relevant policies and procedures and a hazard flow chart to guide staff through the process. The quality manager and a staff member are the health and safety representatives and they have attended education relating to the new health and safety legislation. The quality manager reported they have reviewed and updated the policy and procedures. Documentation reviewed confirmed this. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. These are collated by the quality manager. The original is kept in the residents’ files. Data includes numbers and graphs of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.  Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The CEO and quality manager confirmed there has been one essential notification (Section 31) to the Ministry of Health since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and police vetting.  The service education programme for 2015 and 2016 was reviewed. There was evidence indicating in-service education is provided for staff utilising various methods of delivery including on-line learning, in-house sessions and external education. Individual records of education are maintained as are competency assessments. Education records for each session and in-service education programmes indicated there is good attendance at education sessions.  Care staff are encouraged to complete a New Zealand Qualification Authority education programme. An enrolled nurse is the internal assessor for the programme.  An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.  Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.  Care staff confirmed they have completed an orientation, including competency assessments. Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift. The clinical manager, CEO and a senior RN are on-call after hours. Care staff interviewed reported there was adequate staff available and that they were able to get through the work allocated to them. Residents and families interviewed reported there is a good number of staff on duty to provide them or their relative with a high standard of care. Observations during this audit confirmed adequate staff cover was provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | All necessary demographic, personal, clinical and health information was complete in the residents’ files sampled for review. The name and designation of providers making entries into the resident records were not consistently identifiable. |
| 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. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management, using an electronic medication management system, was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medications are administered by either registered or enrolled nurses, all of whom complete annual competency assessments for this role.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge reviewed were within the recommended range.  There were no residents currently self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner should it be required.  Medication errors are reported to the clinical manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | The food service is provided on site by cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in February 2015.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and monitoring of food returned to the kitchen. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.  The kitchen was clean and well-organised. Some items in the chiller and freezer were not labelled and/or dated. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Residents’ progress notes are updated regularly, and include details of changes of care, although these changes were not consistently reflected in the care plans, and care plans did not consistently include sufficient detail to guide care delivery. Refer also to criteria 1.3.3.3 and 1.3.8.3. Residents and families reported participation in the development and ongoing evaluation of care plans.  All residents and family members, plus two visiting health professionals interviewed during the audit visit advised they were happy with the care provided. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Refer also to criteria 1.3.3.3, 1.3.5.2, 1.3.8.2 and 1.3.8.3.  Reviews of progress notes, discussions with staff, residents and family members and interviews with two visiting health professionals verified the provision of care provided to residents was consistent with their needs. Care plans were individualised, and included strategies to maintain resident independence as appropriate. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that they are confident that an appropriate standard of care is delivered. This was also confirmed by a visiting clinical nurse specialist. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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. | FA | The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy, and a number of volunteers.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated within one month of the initial plan being developed and then six monthly.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include games, entertainment, knit and natter groups, music, exercises, newspaper reading, and regular outings, including combined activities with other residential care facilities and local interest groups. The activities programme is discussed at the monthly residents’ meeting and the diversional therapist advised that residents’ input is sought and responded to. Residents interviewed confirmed they find the programme interesting, varied and enjoyable. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Resident care is evaluated and reported in the progress notes each shift for hospital residents and at least daily for rest home residents.  Formal care plan evaluations occur every six months, although the evaluation of residents’ progress towards identified goals is inconsistent, and when progress is different from expected or new needs are identified the care plans are not consistently updated and/or short term care plans developed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Refer also to criteria 1.3.3.3 and 1.3.5.2. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness is displayed in the entrance to the facility that expires on the 26 January 2017. Documentation from the Ministry of Health requested the two new bedrooms be included in this audit. The chapel room is now able to be used as a bedroom and a large bedroom is now a double room. Both rooms have good space with appropriate heating and a call bell system. The double room has a curtain dividing the two bed spaces, however this does not provide the resident nearest the door with adequate privacy. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, skin/wounds, eye, and respiratory tract infections. When an infection is identified, a record of this is documented in a hard copy register and also in an electronic register. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers, and reported to the General Manager and then to the Board. Graphs are produced that identify trends for the past three months. Data is not currently externally benchmarked.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meeting. Refer also to criterion 1.2.3.6. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There were 13 residents using restraints and two residents using an enabler during the audit. (See criterion 2.2.2.1). The restraint register is current and updated. The policies and procedures have good definitions of restraints and enablers. Staff demonstrated knowledge about restraints and enablers. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low | The clinical manager and quality manager reported an assessment template has been developed and implemented since the last audit. Review of resident files confirmed this. However, the requirements as stated in this standard are not included. This was a finding at the previous audit and remains open. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | The restraint coordinator reported individual evaluation of restraint and enabler use is completed at least three monthly. Resident files evidenced individual evaluation of restraint use and this is completed on a regular basis. The template for the evaluation of individual restraint use does not include the items as stated under the criterion. (Link to criterion 1.3.5.2). |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | PA Moderate | A quality review of restraint was not available and the quality manager reported they do not have a tool to audit restraint use facility wide. Thirteen of the 14 hospital level care residents are using restraint. The restraint coordinator stated they have tried to reduce the use of restraint, however, the clinical manager stated that in some instances, they believe more could be done to reduce the use of restraint. |

# 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 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | All resident files reviewed included a resuscitation status form that had been completed in accordance with the service’s resuscitation policy. The resuscitation policy outlines the requirements relating to consent processes associated with completing the resuscitation status form. The policy does not include a definition of advance directives, or a statement to confirm that advance directives will be acknowledged, incorporated into care planning where valid, and acted on. | The resuscitation policy does not include a statement that resident’s advance directives are incorporated into care planning and are acted on. | Policy and processes are in place to acknowledge advance directives and incorporate these into care planning, where valid and are acted on.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement date is being collected and collated on a regular basis including clinical indicators and graphs are generated. There is some evidence of analysis of data, however this is basic and inconsistent. As a result, there was no evidence of any trends identified apart from graphs. Registered and enrolled nurse meeting minutes and health and safety meeting minutes evidenced reporting of collated numbers of clinical indicators. There was no evidence of reporting and discussion analysis related to quality data. There have been no general staff meetings held this year, apart from one held in September. The CEO reported these are usually held two monthly. Staff reported that staff meetings used to be held on a regular basis. The quality manager reported some current information is provided to staff through regular weekly memos. | Analysis of quality data is inconsistent and basic, resulting in trends not able to be identified. There is no evidence in the meeting minutes reviewed for RN/EN meetings and health and safety meeting minutes and the one general staff meeting of reporting and discussion of analysis and trending of data at these meetings. | Provide documented evidence that quality data is comprehensively analysed to identify trends and reported back to all staff on a regular basis.  180 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 | Corrective action plans are being developed and implemented for deficiencies identified following internal audits and health and safety meetings. The relative and residents’ satisfaction survey for 2015 identified deficits, however, there was no evidence of any corrective action plans. Meeting minutes, apart from the health and safety minutes, do not document who is responsible for the corrective action, time frames for completion and sign off. | Corrective action plans are not being completed following relative and resident satisfaction surveys and meeting minutes apart from health and safety, do not document the staff member responsible for the corrective action, the timeframes and any sign off that the action has been completed. | Provide documented evidence that: (i) corrective action plans are developed, implemented and reviewed following all deficits identified; (ii) meeting minutes state who is responsible for the corrective action, the timeframes for completion and sign off once the corrective action has been completed.  180 days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | Resident progress notes are updated each shift for hospital-level residents and at least once daily for rest-home level residents. Additional entries are made as required. In all the residents’ files reviewed, the progress notes were detailed and legible. Approximately one quarter of all names and/or designations of providers making entries into those progress notes were not identifiable. | The designation and/or names of service providers making entries into the clinical records were not legible and/or the provider is not identifiable. | The name and designation of the service provider is legible in all clinical documentation.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | With the exception of the labelling/dating of food in the chiller, all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately. All kitchen staff have recently completed relevant food handling training, and the operations manager advised that the service has begun work towards having a food control plan registered. The chiller and freezer are well-maintained and temperatures are being maintained within appropriate levels. Although the majority of items in the chiller and the freezer were covered, labelled and dated, approximately six items were not. | Food items in the chiller and freezer are not consistently labelled and/or dated. | All food items in the chiller and freezer are labelled and dated.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | An initial assessment of the resident is undertaken and care plan developed within 24 hours of an admission. Long-term care plans are developed within three weeks of admission. These are based on a range of clinical assessments, referral information, resident and family input and the NASC assessments. A medical assessment is undertaken within 48 hours of admission and reviewed as a resident’s condition changes, or monthly unless the resident’s condition is documented as stable. A full medical review occurs every three months and includes members of the multidisciplinary team. This is verified by sampling residents’ records, interviews and observation. Care plans are reviewed at least six monthly or earlier if clinically indicated as required by the provider’s contract with the DHB.  The clinical manager advised that there are six interRAI assessors on staff. A report generated from the interRAI system confirmed that all current residents had an interRAI assessment completed, but twelve reassessments were now overdue. The clinical manager advised that additional staff had been rostered on to catch up with overdue assessments.  Three of the eight residents’ files reviewed did not include copies of a current interRAI assessment, and there was no evidence of assessment outcomes informing their plan of care. | InterRAI assessments/reassessments are not completed within required timeframes and there is inconsistent evidence of assessment outcomes then informing care planning. | All required assessments are completed within required timeframes and the outcomes of those assessments are consistently used to inform care planning.  90 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 | Eight resident care plans were reviewed. With the exception of the interRAI assessment information (refer to criteria 1.3.3.3 and 1.3.8.3) there was evidence of service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant.  Three of the care plans did not include sufficient detail on the support and/or interventions required to address the needs identified in the assessment process and/or documented in the progress notes. For example, two residents identified as being at risk of developing pressure injuries did not have strategies in their care plans about how to prevent further injuries or minimise the current injuries. The care plan of a resident receiving insulin therapy contained scant information related to the management of their diabetes.  A resident who had bedrails being used as an enabler had no documentation related to the use of bedrails in their care plan. Another resident who had been approved for three different forms of restraint had only one of these restraints noted in their care plan, and neither they nor a third resident for whom a restraint was also being used had detailed plans in place to ensure the safe use of those restraints. | Care plans do not include sufficient detail on the support and/or interventions required to address identified needs.  The documentation related to the safe use of restraint/enablers was incomplete in two care plans and completely absent in a third. | Care plans include appropriate detail on the support and/or interventions required to address identified needs.  When residents are using a restraint or enabler, care plans are developed which include detailed strategies related to their safe use.  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 Moderate | Registered nurses complete formal evaluations of residents’ progress at least six monthly, and these time frames had been met in all of the care plans reviewed, except for the interRAI evaluations. In four of the care plans reviewed, the evaluation of residents’ progress did not include any detail of the resident’s status, but simply indicated that no change to the care plan was required | Resident progress towards meeting identified outcomes was not recorded in sufficient detail in four of the care plans reviewed. | Resident progress towards meeting identified outcomes is comprehensively recorded in all care plans.  90 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | All care plans reviewed during the audit visit had been evaluated within required timeframes. In three of the care plans reviewed, clinical issues had developed which were not then reflected in an updated care plan or a new short term care plan. For example, there was no plan developed when a resident had a urinary catheter inserted. In another instance, a notation on a care plan two months earlier recorded that the resident had experienced weight loss and this should be raised with the doctor at a forthcoming medical review. There was subsequently no evidence available, including from the record of the medical consultation, that the doctor had been advised of this situation, nor had any other changes or updates been made to the resident’s plan of care. | When resident progress is different from expected, or new needs are identified, service delivery plans are not consistently updated to reflect this. | Service delivery plans are updated when resident progress is different from expected, or new needs are identified.  90 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 Low | A curtain rail and curtain runs straight between the two resident’s areas providing privacy for both residents when they are in their beds. Privacy for the resident nearest the door is compromised when there are visitors or the other resident enters the bedroom. | The existing curtain does not provide adequate privacy for the resident whose bed is nearest the door when there are visitors or the other resident enters the bedroom. | Install a curtain railing and curtain so that the privacy of the resident nearest the door is not compromised.  30 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Low | The assessment template has been developed and a sampling of residents’ files evidence implementation. The assessment form does not include all the elements of this criterion. | The template for the assessment of restraint does not include items (a) to (h) as required by this criterion. | Expand the assessment template for restraint to include all the elements as stipulated under this criterion.  180 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Low | The resident’s files sampled who are using restraint and enablers evidenced regular evaluations. The individual evaluation template does not reflect the requirements of this criterion. | The template for evaluation of individual use of restraint does not include items (a) to (k) as required under this criterion. | Develop and implement an evaluation form that includes all the items (a) to (k) as required.  180 days |
| Criterion 2.2.5.1  Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. | PA Moderate | A facility wide quality and monitoring of restraint use was not evidenced. The quality manager reported they do not have a template for auditing restraint use facility wide. This was a finding at the last audit and remains open. Apart from one resident, all residents who have been assessed as hospital level care are using a restraint. The restraint coordinator stated they have been trying to reduce the use of restraint including using high/low beds and sensor mats. The clinical manager reported more needs to be done to try and minimise the use of restraint. | Quality reviews of restraint use across the facility was not evidenced. The quality manager reported there was no tool available to audit restraint. A high number of hospital level care residents are using restraint and although there is individual evaluation of restraint, there was no evidence to indicate that the facility is actively reducing the use of restraint. | Provide documented evidence that: (i) a quality review of restraint use is developed and implemented that includes items (a) to (h) under this criterion; (ii) the facility is actively minimising the use of restraint.  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.