

Tairua Residential Care Limited - Tairua Residential Care

Introduction

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

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

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

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

The specifics of this audit included:

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| Legal entity: | Tairua Residential Care Limited |
| Premises audited: | Tairua Residential Care |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 2 March 2017 End date: 2 March 2017 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 41 |

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
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|  | 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 |
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| | 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

Tairua Residential Care Limited provides rest home and hospital level services (including medical care) for up to 44 residents. On the day of the audit, there were 41 residents, which included two people receiving rest home level carer support services and one rest home resident on leave, and one day patient. The owner is also the nurse manager of the facility. She is a registered nurse with a current practising certificate. She is supported by a team of registered nurses.

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

The service has addressed eight of eleven shortfalls from the previous certification audit around: the analysis of quality data and feedback to staff of quality results, interRAI assessments, wound and pressure injury assessments, medication management in relation to the use of standing orders and the administration of medicines, the testing and calibrating of medical and electrical equipment, first aid/CPR training, equipment calibration and testing, restraint assessments and monitoring of the use of restraint.

Improvements continue to be required in relation to three of eleven shortfalls from the previous certification audit which includes: developing corrective action plans where indicated, medicines management as it relates to self-administration of medicines and care plans being updated to reflect changes in health needs.

This surveillance audit identified that improvements are also required in relation to: the recording of incident forms for all pressure injury and challenging behaviour incidents, essential notification reporting, policy and care planning as it relates to people admitted for respite care, recording of pressure injury interventions.

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. | | Standards applicable to this service fully attained. |
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Communication with residents and families is appropriately managed. Complaints are actioned and include documented responses to complainants. A complaints register is maintained.

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 medium or high risk and/or unattained and of low risk. |
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The philosophy of the organisation is reflected in business planning. Risk management processes are practised to promote the safety of residents and staff. The quality system includes a review of annual objectives, conducting quality activities and the collection of data related to the reporting of adverse events. An internal audit programme and schedule is in place. Policies and

procedures are followed for the recruitment of staff, including police and referee checks. Regular in-service staff training is provided and is well attended. Staffing levels meet contractual requirements and are planned, coordinated, and appropriate to the needs of residents.

Continuum of service delivery

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| <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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Initial assessments and all care plans are completed by the registered nurses. Each resident has access to an individual and group activities programme.

There is a system of medicines management in place. All staff who administer medications have completed a competency assessment. A general practitioner reviews each resident at least three monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

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.

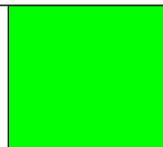


Standards applicable to this service fully attained.

There is a building warrant of fitness in place. There have been no building alterations since the previous audit. Medical and electrical equipment is serviced and the person who takes the residents on outings holds a current first aid/CPR certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. The service was using restraint for three residents and four residents were voluntarily using enablers.

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 annual infection prevention and control programme includes the surveillance programme. The programme is overseen by the infection prevention and control coordinator who is a registered nurse with a current practising certificate. Surveillance activities occur as outlined in the programme. There have been no outbreaks of infection in the period since the previous audit.

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) |
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| Standards | 0 | 14 | 0 | 3 | 3 | 0 | 0 |
| Criteria | 0 | 38 | 0 | 4 | 3 | 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 |
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| <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 has a complaints policy that describes the management of the complaints process. Complaints forms and a suggestions box are located in a visible location at the entrance to the facility. A record of all complaints is maintained by the nurse manager/owner. Two complaints received in 2016 were reviewed and reflected evidence of responding to each complaint in a timely manner with appropriate follow-up actions taken. Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service and were comfortable speaking with the nurse manager/owner if they have a concern. Concerns are dealt with promptly.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Policies and procedures relating to accident/incidents and open disclosure identify staff responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on a 'towards improving service' (TIS) form. Fifteen TIS forms that were reviewed across the rest home and hospital identified family are kept informed. Two relatives (one hospital and one rest home) interviewed stated that they are kept informed when their family member's health status changed. Eight residents (one hospital and seven rest home) interviewed confirmed that they</p> |

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| | | were welcomed on entry and were given time and explanation about the services and procedures. |
| <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> | FA | <p>Tairua Residential Care is able to provide care for up to 44 residents at rest home and hospital (including medical) levels of care. The service has 32 beds at rest home level and 12 beds at hospital level. There are no dual purpose beds. At the time of the audit the facility was occupied with 41 residents in total, 31 residents receiving rest home level care and 10 residents receiving hospital level care. Two rest home residents were receiving respite care. All other residents were under the Aged Related Residential Care (ARRC). One person was receiving day patient services under an individual agreement with the DHB.</p> <p>The owner of the facility is the nurse manager, who holds a current annual practising certificate as a registered nurse (RN). She purchased the facility in 2011 and continues to work full time as the nurse manager. A business, quality and risk management plan describes the five key goals of the facility. Each goal describes the objectives, management controls, measurements and allocated responsibility. The nurse manager/owner has completed in excess of eight hours of professional development in the past year.</p> |
| <p>Standard 1.2.3: 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> | PA Low | <p>The service has a quality programme in place with the nurse manager/owner having overall responsibility for the quality plan. 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 policy. There is a document control system in place to manage the policies and procedures.</p> <p>Quality goals are defined for the service. An internal audit programme and schedule is in place. There is no internal audit tool to audit pressure injuries. A group of staff assist with the internal audit programme. Internal audit results and adverse event data are analysed and discussed at the monthly staff meetings. The nurse manager/owner is responsible for the document management process and review and updating of policies and procedures.</p> <p>Service delivery is monitored through internal audits, incident and accident reporting, complaints management, infection prevention and control monitoring, and health and safety compliance.</p> <p>A resident/relative satisfaction survey is carried out annually to gain</p> |

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| | | <p>feedback.</p> <p>Corrective actions developed have not been evaluated, followed up and signed off for internal audits and the resident/relative satisfaction survey, which was a previous finding of the certification audit.</p> <p>The service has a risk management plan in place that documents risks associated with the service. The hazard register identifies hazards. All identified hazards have risk management strategies. A safety audit is conducted annually. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>PA Moderate</p> | <p>Incident and accident data are collected and analysed. Fifteen TIS forms were reviewed which included evidence that appropriate clinical care is provided following an incident. Reports were completed and family were notified as appropriate. There is an incident reporting policy that includes definitions and outlines responsibilities including immediate actions, reporting, monitoring and corrective actions. Discussions with the nurse manager/owner confirmed that she is aware of the requirement to notify relevant authorities in relation to essential notifications although a recent incident was not notified as a Section 31 event and this was actioned on the day of audit once the omission was detected.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Five staff files (two RNs, two caregivers and one cook) were reviewed and included all appropriate human resource documentation. Each position has a job description that meets accepted standards. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. There are human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Professional qualifications are validated. A copy of practising certificates are kept.</p> <p>The service has an orientation programme that provides new staff with relevant information for safe work practice.</p> <p>Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals have been conducted for all staff files reviewed. There is a completed in-service training calendar, which exceeds eight hours of</p> |

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| | | training annually. Caregivers are supported to complete an on-line caregiver training course. A RN is responsible for facilitating the education programme. The nurse manager/owner and RNs attend external training including conferences, seminars and education sessions with the local DHB. |
| <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> | FA | <p>There is a skill mix policy in place. There is a four weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one RN and one caregiver on duty at all times. The full time nurse manager/owner is also a RN. The nurse manager/owner lives on site and is available on call 24/7. Caregivers advise that sufficient staff are rostered on for each shift. All RNs are trained in first aid.</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> | PA Moderate | <p>There is a medicines management system in place and policies, procedures and forms to guide practice. Medications being administered by staff were securely stored when not in use. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medication charts are written correctly by medical practitioners and there was evidence of three-monthly reviews by the GP.</p> <p>Medications are administered by registered nurses, an enrolled nurse and senior caregivers. These staff have completed annual medication competencies and medication education. An RN was observed administering medications safely.</p> <p>The service no longer uses standing orders. Medicines were administered in a timely manner and recorded appropriately</p> <p>There were four rest home residents self-administering medicines at the time of the audit. All four residents had a current competency assessment in their records and had signed an agreement regarding their responsibilities. There was evidence of three monthly reviews by the general practitioner. The medicine orders for all four residents did not identify the medicines that each resident was self-administering. There was no evidence in the administration signing sheet that staff had checked that these residents had taken their medications as prescribed each shift. One of the four residents self-administering their medicines had access to secure storage in their room.</p> <p>Fourteen sets of medication charts were reviewed, which included nine rest home residents (four of whom were self-administering and two were</p> |

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| | | receiving carer support) and five hospital level residents, all were legible and charts evidenced photographs. Medication profiles reviewed consistently evidenced that allergies were documented and that the GP had reviewed the resident's medications at least three monthly. 'As required' medication consistently evidenced indications for use. |
| <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> | FA | <p>There is a functional kitchen and all food is cooked on site by two cooks. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The kitchen is able to meet the needs of residents who need special diets. Kitchen staff have completed food safety training. Menus are reviewed by a dietitian. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were happy with the quality and variety of food served.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | PA Low | <p>Two people were admitted for rest home level carer support (respite care). One had been admitted a week ago for emergency respite care which was arranged by the community mental health team (Mental Health Services for Older People). The other person had been admitted several weeks ago for rest home level carer support and an initial care plan had been completed by a registered nurse. The policy on admission is silent on the documentation requirements for people receiving respite care.</p> <p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed on admission and were reviewed at least six monthly or when there was a change to a resident's health condition. Care plans reviewed were developed on the basis of these assessments. Pain and continence assessments (where applicable) were in place in the files reviewed.</p> <p>InterRAI assessments for long term residential care residents are completed within 21 days of admission. Three RNs are currently able to conduct interRAI assessments and a forth RN is booked for interRAI training.</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> | PA Low | <p>All long term residential care residents have an assessment which includes an interRAI assessment. A review of the five care plans of long term residential care residents showed that all needs identified in the assessment process were itemised in each of the resident's plan of care. Registered</p> |

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| | | <p>nurses (RNs) and caregivers follow the care plans and report progress against the care plan each shift.</p> <p>Nursing staff have links to external health care agencies. If external nursing or allied health advice is required the RNs will initiate a referral. If external medical advice is required this will be actioned by the general practitioners (GP). Specialist continence advice is available as needed and this could be described.</p> <p>Continence products are available and residents' files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Dressing supplies are available and a treatment room/cupboard is stocked for use.</p> <p>Wound assessments and wound management plans were in use for four hospital level residents with wounds on the day of the audit. One was a pressure injury, one had a skin lesion and two had skin tears. There were six residents in the rest home who had wounds (four residents had lesions, one had a skin tear and one had a chronic ulcer).</p> <p>Care plan interventions included regular turns which were intermittently documented in the progress notes.</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>FA</p> | <p>The service has two activities coordinators who both work full time. One is based in the hospital area and one is based in the rest home area.</p> <p>Each resident has an individual activities assessment completed on admission. This assessment is used to formulate an individual activity care plan which is reviewed six monthly or as required when the interRAI assessment occurs.</p> <p>The group activities programme is planned and all residents are invited to attend activities in either area. The service has a five day weekly programme and activities were observed occurring. In addition to the week day activities volunteers attend on Saturday's to provide bowling for the residents. Every Sunday there is a Catholic communion service held. On-on-one time occurs on an individual basis for those residents who choose not to participate in activities. There is a variety of activities provided. A van is available for residents' outings. The van driver is a volunteer. Residents enjoy weekly outings and shopping trips. Community links are maintained with groups and individual visitors. A church service is held every Monday.</p> |

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| | | Residents and relatives expressed satisfaction with the activities offered. |
| <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>All initial care plans of residents receiving long term residential care were evaluated by the registered nurse within three weeks of admission. All care plans of the five residents receiving long term residential care were reviewed by the RN six monthly or when the resident's needs changed. There was evidence of at least a three monthly review by the GP in the files of long term residents included in the sample reviewed. Short term care plans were evaluated and resolved or added to the long term care plan if the problem was on-going. The RNs record who is due for review on a whiteboard and document the need for the review in the communication book. Care plans were not always updated where progress was different from expected. This remains a finding from the previous audit.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>The building has a current building warrant of fitness expiring 22 September 2017. There have been no alterations to the building since the previous audit. Medical and electrical equipment has been serviced and calibrated within the last 12 months.</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>There is a surveillance programme in place which includes a range of surveillance activities. The programme is overseen by the nurse manager/owner who is registered nurse. She acts as the infection prevention and control coordinator. Surveillance is ongoing. Data are recorded and monitored. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. The infection rate is low. The majority of infections are urinary tract infections. There have been no outbreaks of infection in the period since the previous audit.</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 restraint policy includes the definitions of restraints and enablers and restraint procedures. Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had four residents voluntarily using bed rails as an enabler. The use of enablers is linked to the resident's care plan with signed consent processes in place. Three residents were using restraints.</p> |

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| <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>The certification audit identified that a restraint evaluation tool form was being used in place of a restraint assessment tool and assessments were not completed in files sampled. A review of all three residents on restraint (bedrails) showed that all three residents had been assessed using the correct assessment form. Assessments are undertaken by the RN and GP. Consent is obtained from the resident's next of kin. The restraint coordinator (owner/manager) is a registered nurse (RN). The RNs are responsible for ensuring all restraint documentation is completed.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | <p>FA</p> | |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | <p>FA</p> | <p>Restraint is only used as a last resort to assure resident safety. Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints in use included bed rails. Restraint authorisation is in consultation/partnership with the resident and family, the GP and the RN.</p> <p>Staff are instructed to document evidence of monitoring safe restraint use in the resident's progress notes using a column designated for restraint monitoring.</p> <p>There was documented evidence of regular monitoring for all three residents on restraint which was consistent with the specified monitoring requirements as listed in their restraint assessment forms.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</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) |
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| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | PA Low | <p>Internal audit results are completed and include a summary that documents findings and recommendations. Corrective actions and recommendations developed have not been evaluated, followed up and signed off for internal audits and the resident/relative satisfaction survey. There is no internal audit tool for pressure injuries. (Link to 1.3.6.1)</p> | <p>Corrective actions developed have not been evaluated, followed up and signed off for all internal audits and the resident/relative satisfaction survey and there is no internal audit tool for auditing pressure injuries. This was a finding at the previous certification audit.</p> | <p>Ensure there are processes in place to evaluate, follow up and sign off corrective actions that are developed for internal audits and the resident/relative satisfaction survey and ensure there is an internal audit tool for pressure injury management.</p> <p>90 days</p> |
| <p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and</p> | PA Low | <p>The nurse manager/owner is aware of the need for statutory and other essential reporting. A Section 31 Notice had been completed for the resident who had a Stage 3 pressure injury and sent to the Ministry of Health with a copy to the District Health Board.</p> | <p>A Section 31 notice had not been completed for a resident involved in the serious incident of challenging behaviour which involved the Police being called and the resident being sectioned under the Mental Health Act and transferred to a secure</p> | <p>Ensure that all obligations for essential reporting occur in a timely manner.</p> <p>90 days</p> |

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| the correct authority is notified where required. | | | facility at the District Health Board. The Section 31 notice was completed on the day of audit and a copy provided to the Ministry of Health and the District Health Board. | |
| <p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p> | PA Moderate | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. | There was no incident form completed for a resident with a pressure injury; and there were no incident forms completed for a resident who exhibited challenging behaviours over a period of two months prior to a serious incident occurring. | <p>Ensure that incident and accident forms are completed for adverse events.</p> <p>90 days</p> |
| <p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p> | PA Moderate | Four rest home residents were self-administering medicines. All four residents had a current competency assessment in their records and had signed an agreement regarding their responsibilities. There was evidence of three monthly reviews by the general practitioner. Medications were securely and appropriately stored for one of the four residents. | The medicine orders for all four residents did not identify the medicines that each resident was self-administering; there was no evidence in the administration signing sheet that staff had checked these residents had taken their medications as prescribed each shift; and three of four residents did not have access to secure storage for the medicines they were self-administering. The management of residents self-administering medicines was a finding at the previous certification audit. | <p>Ensure the documentation of residents who self-administer medicines complies with current guidelines.</p> <p>60 days</p> |
| <p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of</p> | PA Low | The needs of residents receiving long term care are identified by the assessment process. An interRAI | One of two people admitted for carer support did not have any documentation related to | Develop and implement policy on people receiving respite services. |

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| consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | | assessment is conducted by a RN and the assessment serves as the basis for service delivery planning. | assessment and service delivery and there is no policy to guide practice. | 90 days |
| Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Residents' needs are identified through the assessment process. Needs are then documented in the resident's plan of care. | Two residents were required to be turned two hourly for pressure area management (one with a PI and one who has the potential to develop a PI). The practice is for staff to record the turning of residents in the progress notes. This was not occurring consistently by staff on all shifts when the patient was in bed. | Ensure the documentation of two hourly turning of residents occurs in progress notes and the procedure is monitored through the internal audit programme. 60 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 | RNs are required by policy to update the resident's plan of care where their progress is different from expected. The review of five resident's files receiving long term care showed that three of five care plans reflected current needs. | Two of five care plans had not been updated when progress differed from expectations. The care plan of the resident with the pressure injury had not been updated to reflect the changes to service delivery, and the care plan of one rest home resident was not updated following a skin tear and there is no wound documentation on record regarding the skin tear. This was a finding at the previous certification audit. | Ensure changes in health status of residents are recorded in their care plans. 60 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.