

# St John's Parish (Roslyn) Friends of the Aged and Needy Society - Leslie Groves Home and Hospital

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## 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:

<b>Legal entity:</b>	St John's Parish (Roslyn) Friends of the Aged and Needy Society
<b>Premises audited:</b>	Leslie Groves Home  Leslie Groves Hospital
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 21 March 2017 End date: 22 March 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	102



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Leslie Groves Home and Hospital is operated by the St John's Parish (Roslyn) Friends of the Aged and Needy Society. The service cares for up to 71 residents requiring hospital level, psychogeriatric and dementia level care on one site and 34 residents requiring rest home level care at a second site. On the day of the audit there were 68 residents in the units at the hospital site and 34 residents at the rest home.

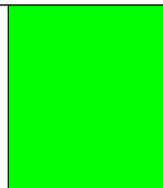
This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

Five of seven shortfalls identified at the previous audit have been addressed. These were around informed consent, admission agreements, first aid training, conducting neurological observations and care plan evaluations. Further improvements continue to be required around aspects of medication documentation and staff training in dementia.

The audit identified improvements required around completion of assessments within the required timeframes, care planning and ensuring the hospital has a current building warrant of fitness.

## Consumer rights

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

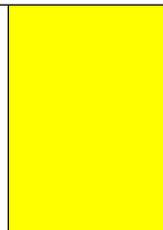


Standards applicable to this service fully attained.

Residents and family are well informed including changes in resident's health. The chief executive and rest home unit manager have an open-door policy. Complaints processes are implemented and complaints and concerns are managed and documented with learning's from complaints shared with all staff.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of low risk.

Leslie Groves has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Leslie Groves is benchmarked against another aged care provider. Incidents are documented and there is immediate follow up from a registered nurse. There are comprehensive human resources policies in place. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses the resident and develops the care plan with the resident and/or family/whānau input. Resident files demonstrated service integration. Care plans were reviewed at least six-monthly.

Medication policies reflect legislative requirements and guidelines. All staff administering medications had completed annual competencies for medication administration. There are three-monthly GP medication reviews.

The activities programmes include community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme.

Food services are contracted to a food service company who work from the Leslie Groves Hospital and transport meals to the rest home. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements were being met. The menu is designed by a dietitian with summer and winter menus. There are nutritious snacks available 24 hours.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The rest home has a current building warrant of fitness. The hospital documentation for building warrant of fitness is currently with the local council waiting approval.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were no residents requiring the use of a restraint and 13 hospital residents had requested to use enablers.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with another aged care provider. Staff receive ongoing training in infection control. The service had a Norovirus outbreak in 2016 which was evidenced to be well managed.

### 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)
<b>Standards</b>	0	14	0	2	3	0	0
<b>Criteria</b>	0	38	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the nine residents' files reviewed (three rest home, two hospital, two psychogeriatric and two dementia rest home). The policies on advance care planning, advance directives, medically initiated health care decisions and cardio pulmonary resuscitation were reviewed and updated in August 2015. The previous finding has been addressed. Advance directives are on the residents' files as appropriate. Resuscitation plans for competent residents were appropriately signed. The previous audit finding has been addressed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions. Future Health Care Decision Forms were evidenced completed and signed by a GP where resuscitation was not medically indicated due to medical diagnosis or prognosis.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had been provided.</p> <p>Long-term resident's files reviewed had a signed admission agreement. This is an improvement on the previous audit.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. A record of all complaints received is maintained by the care home manager using a complaints' register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner (HDC).</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestion box are placed at reception.</p> <p>Eight complaints were received from January 2016 to date and reflected evidence of responding to complaints in a timely manner with appropriate follow-up actions taken. All eight complaints were signed off by the chief executive as resolved. There is one HDC complaint that remains open from 2014. The quality manager advised that recently the service had been requested to provide more information which they had duly sent.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twenty incidents/accidents forms were viewed. The accident/incident form includes a section to record family notification. All 20 forms indicated family were informed. Families interviewed confirmed they were notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Leslie Groves is owned and operated by the St John's Parish (Roslyn) Friends of the Aged and Needy Society. The board meets monthly and provides a governance role. The service provides care for up to 105 residents at hospital (geriatric and medical), psychogeriatric, dementia and rest home level care. On the day of the audit, there were 102 residents in total (34 residents at rest home level, 15 residents in the dementia unit, 23 residents in the psychogeriatric unit and 30 residents at hospital level). The dementia, psychogeriatric and hospital levels of care are provided at one site and the rest home level care is provided at a second site.</p> <p>The service is managed by an experienced chief executive who has been in the role for 14 years. The chief executive was on annual leave at the time of audit. The chief executive reports monthly to the board. The chief executive is supported by a clinical nurse specialist and a quality manager who is also a registered nurse. There is a full-time unit manager who is a registered nurse, at the rest home site. The 2017 strategic plan and operation/quality plan have been implemented. The chief executive and rest home unit manager have completed at least eight hours of training related to management of a rest home and hospital in the past year.</p>

<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and at the board meetings. Discussions with the quality manager, rest home unit manager and staff reflected staff involvement in quality and risk management processes.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There are policies around assessment and reassessment in place. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls, infection rates, complaints received, restraint use, pressure areas, wounds and medication errors. Quality and risk data, including trends in data are discussed in the two-weekly management meetings, monthly registered nurse (RN) meetings and unit meetings. The service benchmarks clinical indicator data against another local aged care provider's results. An annual internal audit schedule is implemented. Corrective actions are established, implemented and are signed off when completed.</p> <p>Residents and relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to staff and families. Feedback from the June 2016 resident/relative survey evidenced overall satisfaction with care and communication.</p> <p>Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety committee. Two health and safety representatives were interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms. Strategies to reduce fall include: implementing toileting plans, bringing residents into communal areas where they can join in activities and be observed by staff and regular monitoring of residents assessed as at high risk of falls when in their rooms.</p> <p>The service is currently completing a project around pressure injury prevention.</p> <p>Reported incidents of challenging behaviour in the psychogeriatric unit have reduced from 20% in 2015 to 6 % in 2016. Increased staff education on the management of challenging behaviours, falls prevention, using the Stop and Watch acronym for improving caregiver report writing in progress notes and regular monitoring of medication</p>

		management in liaison with the nurse practitioner has been attributed for the reduction in falls.
<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>	FA	<p>Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Neurological observations are conducted for unwitnessed falls. This previous audit finding has been addressed. Data collected on incident and accident forms are linked to the quality management system.</p> <p>The quality manger (who was in charge at the time of audit while the chief executive was on annual leave) and rest home unit manager interviewed are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided.</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>	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files reviewed (two RNs, seven caregivers and one activities coordinator) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction.</p> <p>Thirty caregivers are employed to work in the dementia and psychogeriatric units with twenty-seven having completed their national dementia qualification. Three caregivers are in the process of completing their qualification and have been employed for over one year. This previous audit finding has not been addressed. Although progress has been made since the previous audit this requirement has still not been fully met.</p> <p>Registered nurses are supported to maintain their professional competency. Sixteen registered nurses are employed and eight have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Leslie Groves has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents.</p> <p>The rest home unit manager, the psychogeriatric unit manager and the quality manager (all registered nurses) all work 72 hours/fortnight. The chief executive and the clinical nurse specialist, each work full-time.</p> <p>There is one registered nurse on duty each shift to cover 24 hours per day in each of the psychogeriatric and hospital units. Dementia unit registered nursing cover is provided by a part time registered nurse, the nurses in the hospital and on call RNs afterhours. There are two enrolled nurses rostered to work in the dementia unit on morning and afternoon shifts on a four on four off roster.</p> <p>In the rest home, there is a registered nurse on duty 28 hours per week in addition to the Nurse Manager, a registered nurse, who works 36 hours/week. After hours on call cover is provided by senior registered nursing management staff. The person on call is documented on the roster. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift. The caregivers reported that there is an overlap of registered nursing staff on each shift in the psychogeriatric and hospital units which assists to improve the handover process and the continuity of care provision.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The service uses an electronic medication management system. Registered nurses reconcile medications on delivery. All medications are stored safely. Medication charts sampled have been reviewed three-monthly by the attending GP. Resident photos and documentation of allergies are evident on all 18 medication charts reviewed. There were no standing orders on the day of audit. There were five expired medications at time of audit.</p> <p>Two of eighteen medication charts reviewed did not evidence that the GP has recorded indication for use for 'as required' medication. The previous audit finding remains. 'As required' (prn) medication was reviewed by a registered nurse each time prior to administration. All discontinued or short course medication records had been completed by the GP. There was no evidence of transcribed medications on administration records. The service has addressed this previous finding.</p> <p>There is a self-medicating resident's policy and procedure in place. There was one resident self-medicating on the day of audit and all competencies were complete.</p> <p>An annual medication administration competency was completed for all staff administering medications and medication training has been conducted.</p>
<p>Standard 1.3.13:</p>	<p>FA</p>	<p>There is an external contractor providing the food services for all Leslie Grove residents. The contracted company</p>

<p>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>uses a commercial kitchen at the hospital site. A dietary assessment is made by the RN as part of the assessment process and this includes likes and dislikes. Nutritional profiles are available in a folder for kitchen staff to access. This includes consideration of any particular dietary needs (including cultural needs). Nursing staff complete a daily resident preference (two choices offered for main dinner served at midday). The menu is a four-weekly seasonal menu. There is evidence of residents receiving supplements. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers is covered and dated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. The external contractor conduct audits as part of their food safety programme. Special or modified diets are catered for. Soft and puree dietary needs are documented in files sampled. Food is transported to each unit (including the rest home) via hot boxes. Resident and families interviewed were complimentary of the food service.</p> <p>There is evidence that there are additional nutritious snacks available over 24 hours. Sandwiches, fruit and biscuits are available in each unit.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>All residents were admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information was gathered during admission which formed the basis of resident goals and objectives in files sampled. Currently seven registered nurses have completed interRAI training. InterRAI assessments have not always been completed to identify current resident needs within required timeframes. The previous audit finding remains an area for improvement. Staff interviewed are familiar with current resident needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described. Dressing supplies are available and all treatment rooms are stocked for use. Wound management policies and procedures are in place. The service is currently managing seventeen wounds including two pressure related injuries. All wounds had wound management plans in place. The pressure related wounds have a care plan written, however, one resident's file sampled did not include pressure prevention measures. Chronic wounds have been linked to the long-term care plans. There is external specialist input into residents. The nurse practitioner for mental health of older persons visits regularly. Strategies for the provision of a low stimulus environment could be described.</p> <p>Long-term care plans reviewed did not always document interventions or updates to interventions when a resident's health changes. Monitoring occurs for vital signs, challenging behaviour, wounds, restraint and continence. However, weight, BSLs, pain monitoring and effectiveness of analgesia were not always recorded. The previous audit finding relating to interventions and monitoring remains an area for improvement. Registered nurses review</p>

		<p>the monitoring charts and report identified concerns to the GP, nurse practitioner or nurse specialist.</p> <p>Short-term care plans document appropriate interventions to manage short term changes in health.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>	FA	<p>The service has two qualified diversional therapists (DT) and two activities coordinators who are completing the DT qualification. The activity team provide a separate activity plan for each home (rest home, hospital, dementia, psychogeriatric) and cover seven days per week in psychogeriatric unit, five days in the hospital, five days in the dementia unit and nine days per fortnight in the rest home. The activity programme is planned monthly. Activities planned for the day are displayed on noticeboards around the rest home and hospital areas. An activity plan is developed for each individual resident based on assessed needs of the functional activity assessment completed on admission. Activity plans were reviewed six-monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Community groups are invited to participate in the programme. The service has a van that is used for resident outings. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents</p> <p>A social history is completed on admission and information gathered is included in the care plan. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six-monthly.</p> <p>Caregivers were observed at various times through the day diverting residents from behaviours. The programme observed is appropriate for older people with dementia related conditions.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated at least six-monthly and were updated as changes were noted in care requirements in files sampled. However, interRAI assessments have not been completed when there was a change in the resident's needs or medical condition (link 1.3.4.2). The care plan evaluations are resident focused and describe residents progress to meeting identified goals. This precious finding has been addressed. When health status changes acutely, short-term care plans were utilised and any changes to the long-term care plans had been dated and signed in files sampled.</p> <p>All initial care plans are evaluated by the RN within three weeks of admission.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an</p>	PA Low	<p>The quality manager and a telephone conversation with the external contractors that complete the building warrant of fitness monthly checks confirmed that the necessary paperwork has been sent to the local council and they are waiting for the certificate to be issued.</p>

appropriate, accessible physical environment and facilities that are fit for their purpose.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	There is a member of staff on duty on each shift who holds a current first aid certificate. All registered nurses have completed first aid training and certificates sighted are current. The quality manager and rest home unit manager have completed external education, New Zealand Resuscitation Council level one, to become first aid trainers and provide training and education to staff. This previous audit finding has been addressed.
<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>	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The quality manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet. The data has been monitored and evaluated monthly and annually at facility and organisational level. Norovirus outbreak in June 2016 was evidenced to have an infection log, notification to the necessary authorities completed and debrief meetings had occurred.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service is committed to restraint minimisation and safe practice which was evidenced in the restraint policy and interviews with clinical staff. Policies also include managing patient's challenging behaviours, alternatives to restraint and guidance for staff in responding to challenging behaviours and patients' needs. The service endeavours to provide a restraint-free environment. Restraint minimisation is overseen by a restraint coordinator who is the clinical nurse specialist. There are 11 hospital residents documented as using enablers. Consents have been completed by the competent resident or relative. A full assessment is completed prior to implementing the enablers and monitoring is documented in progress notes.

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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is an annual education schedule that is being implemented. In addition, opportunistic education is provided at handover of shifts. A competency programme is in place with different requirements according to work type (e.g. caregiver, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained – competency register sighted. Education on cultural awareness was provided to staff in October 2015. This previous audit finding has been addressed. Not all staff who have been employed for over one year have completed their dementia-specific national qualification. All three of these staff work regularly in the dementia and psychogeriatric units. Although the service has made progress in addressing this requirement the requirements have not yet been met.</p>	<p>Three caregiving staff who work regularly in the dementia and psychogeriatric units have not completed their dementia-specific national qualification. All three staff members have been employed for over one year.</p>	<p>Ensure all caregiving staff working for over one year in the dementia and psychogeriatric units complete a dementia-specific national qualification.</p> <p>60 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>This audit reviewed: electronic medication records, three medication stock rooms, fridges and four medication trolleys (rest home, hospital, and dementia and psychogeriatric unit). There were expired medications present. Medications that require two nurses are stored safely and checked by two staff when administered.</p>	<p>(i)There were five expired medications (two eye drops on trolleys and three Nitro-lingual sprays in cupboards); (ii)Two eye drops, were not dated on opening.</p>	<p>(i)Ensure all expired medications are returned to the pharmacy for safe disposal of medicine. (ii) Ensure eye drops are dated on opening.</p> <p>30 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>The service has in place policies and procedures for ensuring all medicine related recording and documentation is: legible, signed and dated and meets acceptable good practice standards. Sixteen of eighteen medication charts reviewed evidenced the GP has recorded 'indications for use' for 'as required' medication. Aspects of the previous audit finding remains open.</p>	<p>Two of eighteen medication charts reviewed did not have 'indications for use' for 'as required' medication.</p>	<p>Ensure that the reason for 'as required' medication is documented on the resident's medication chart.</p> <p>30 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process</p>	<p>PA Moderate</p>	<p>Risk assessment tools are utilised when needs are identified, including pressure risk, nutritional, falls prevention, behavioural and pain. Four of the nine files reviewed document completed interRAI assessment for all identified needs. Registered nurses, enrolled nurse and caregivers interviewed are familiar with the needs of the residents.</p>	<p>Of the nine resident files reviewed: (i) three (two rest home, one psychogeriatric) did not include an interRAI reassessment six-monthly;</p>	<p>(i-ii) Ensure all residents have interRAI assessments completed within the specified</p>

<p>and are documented to serve as the basis for service delivery planning.</p>			<p>(ii) one rest home file had no interRAI completed; (iii) one psychogeriatric file did not have an interRAI reassessment when the resident's condition changed.</p>	<p>timeframes; (iii) Ensure interRAI reassessments are completed when a resident's condition changes.</p> <p>60 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Five of nine files reviewed identified that the care plans include interventions to guide care. Care plans require monitoring of weight monthly, however, three of nine files do not evidence monthly monitoring of weight.</p>	<p>(i) Four of nine resident files sampled (one rest home, one hospital, one dementia and one psychogeriatric) did not have interventions documented in sufficient detail to guide staff. Examples include: falls prevention, behaviour, asthma management, mobility, nutrition, pain, pressure injury management and prevention.</p> <p>(ii) Four resident files (one rest home, one psychogeriatric and two hospital) did not include monitoring and assessment of pain and effectiveness of 'as required' medication administered.</p> <p>(iii) The monitoring of</p>	<p>Ensure all interventions are documented to support resident's current needs. Ensure monitoring requirements are completed as directed by the care plan.</p> <p>90 days</p>

			<p>BSL is not documented as completed for one PG resident as per GP instruction.</p> <p>(iv) Two resident files sampled identified that the monthly weighs have not occurred (one rest home resident had weight recorded two to three monthly and one hospital resident had no weights recorded from November 2016 to March 2017).</p>	
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>The quality manager and a telephone conversation with the external contractors that complete the building warrant of fitness monthly checks confirmed that the necessary paperwork has been sent to the local council and they are waiting for the certificate to be issued.</p>	<p>The building warrant of fitness had expired 16 March 2017 in the hospital. The rest home building holds a current warrant of fitness which expires 16 May 2017.</p>	<p>Ensure a current building warrant of fitness for the hospital is obtained.</p> <p>30 days</p>

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

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

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

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

No data to display
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End of the report.