# Nurse Maude Association - Nurse Maude Hospital

## 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:** Nurse Maude Association

**Premises audited:** Nurse Maude Hospital

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

**Dates of audit:** Start date: 6 June 2017 End date: 8 June 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:** 31

# 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

Nurse Maude Hospital provides rest home and hospital level care for up to 36 residents. The service is operated by the Nurse Maude Association and managed by a general manager, and a clinical nurse manager. There have been no changes to the service nor facilities since the previous audit. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the Canterbury District Health Board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner.

This audit has resulted in one area requiring improvement relating to monitoring of restraints. Improvements have been made to informing residents of the Code of Rights, to recording and completion of training, and planning and evaluation of residents’ care, addressing the four areas requiring improvement identified at the previous audit.

## 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. |

Open communication between staff, residents and families is promoted, and was confirmed to be effective and a strength of the service. There is access to interpreting services if required. The Code of Health and Disability Services Consumers’ Rights (the Code) was available and known to residents.

Complaints and feedback are seen as an opportunity to make improvements. A complaints register is maintained with complaints resolved promptly and effectively.

## 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. |  | Standards applicable to this service fully attained. |

Strategic, business and quality and risk management plans include the scope, direction, values and mission statement of the organisation, with a focus on combining plans to simplify and better integrate workstreams. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the organisation.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## 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. |  | Standards applicable to this service fully attained. |

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Changes are made to short and long term care plans as indicated.

The planned activity programme provides residents with a variety of individual and group activities. Personalised Te Ora plans and the wider programme reflect a holistic approach.

An electronic system enables medicines to be safely managed. The storage and monitoring of medicines meet requirements. Only registered nurses administer medicines and all have a range of completed medication competencies.

The kitchen and food service has a Hazard Analysis and Critical Control Point (HACCP) certification for food safety. A four week rotating menu has been reviewed by a dietitian to ensure the nutritional needs of the residents, including special requirements, are met. 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. |  | Standards applicable to this service fully attained. |

There is a current building of warrant of fitness. There have been no changes to the hospital building since the previous audit.

## Restraint minimisation and safe practice

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

Organisational policies and procedures reflect the reported philosophy that any use of a restraint is a last resort. Nurse Maude actively minimises the use of restraint. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff are aware of the requirements around the assessment, approval and evaluation of restraint use.

## 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. |

The infection prevention and control programme includes comprehensive surveillance activities across the organisation. The criteria for infection surveillance relevant to each Nurse Maude service have recently been reviewed. These are based on those recommended for long stay care facilities. Data is reported and collated monthly and includes analysis of patterns and trend in the results. These are reported through to senior management through the committee structure. Low rates of infection are recorded, with limited use of antibiotics.

## 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 | 18 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 42 | 0 | 1 | 0 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and process meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.  The complaints register reviewed and discussed with the quality coordinator, showed that nine complaints have been received over the past year, across all the Nurse Maude services (that is hospital, hospice and community services), and that actions taken, through to an agreed resolution, were documented and completed within the required timeframes. Action plans show any required follow-up and that improvements have been made where possible. The quality coordinator manages the overall complaints process, with the relevant general manager, clinical nurse manager and quality facilitator involved in the investigation and development of any action plan required. Staff interviewed understood the complaint process and what actions are required, should a resident or family member wish to make a complaint. There have been no complaints received from external sources since the previous audit for the hospital service. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information about the Code of Health and Disability Services Consumers’ Rights (the Code), is included in an admission information pack. The admission pack is provided to residents and family members at the time of admission and registered nurses informed they discuss all the information in the pack to the resident and family members. A copy of the Code is on display and additional brochures are available at the front entrance. Family members and residents interviewed were familiar with the Code, with some being more familiar than others. All who were able to respond, also knew about the advocacy service. The corrective action raised at the previous audit has been satisfactorily addressed. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The informing of family members following an adverse event was also noted on incident forms reviewed. Communication with residents and family members was noted as a strength of the service. Regular ‘Whanau forums’ are held in the ward and meeting minutes reviewed demonstrated that this was an effective forum for feedback.  Staff knew how to access interpreter services, although reported this was rarely required due to staff and family members being able to provide interpretation as and when needed, for the two residents who do not speak English. |
| 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 Strategic Overview 2016-2020, updated in October 2016, outlines the vision, mission and values of the organisation along with national and regional context and strategic direction and objectives. The key planned development for the aged residential care service is the new aged care residential facility being built on site and due for completion by September 2018. Advancing the use of information technology to support all aspects of service delivery continues to be a further key area of strategic development. The planning process was discussed with three members of the Senior Management Team and demonstrated both a responsive and innovative approach to development of services to meet the changing needs of the population.  A sample of reports to the Board of Directors, Board Quality & Risk Sub-committee, Clinical Governance Group, and the Annual Report 2016, showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, quality and safety.  The service is managed by an experienced chief executive who is supported by the Senior Management Team (SMT) of nine, including the Director of Nursing and the General Manager of Care Coordination and Specialist Services, who oversees the aged care facility hospital. The hospital is managed by a Clinical Nurse Manager who is skilled and experienced in this role. Authority and accountability is defined through job descriptions and the organisational charts. Managers interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through attending conferences, membership of a wide range of local, regional and national committees and forums and ongoing professional development.  The service holds contracts for the aged care hospital facility for respite care, hospital care, and palliative care. On the first day of the audit there were 25 residents receiving hospital level care and six residents receiving palliative care. |
| 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. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of clinical incidents, including infections, falls, pressure injuries, restraint and skin tears. The organisation participates in two external accreditation programmes.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the Clinical Governance Group meeting, quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management through audit activities and discussion of incidents and quality improvement projects. The quality facilitator supports staff and the quality activities within the hospital and discussed several improvements to patient outcomes as a result of improvement methodology (e.g., a reduction in falls with injuries, a reduction in skin tears and pressure injuries and reduced use of restraint). Relevant corrective actions are developed and implemented to address any shortfalls. A centralised Corrective Action Register tracks progress with implementation.  The most recent resident and family satisfaction survey showed a 23 percent increase in satisfaction with the activities programme, improved satisfaction with the food service, and a decrease in satisfaction around understanding the complaints process. Actions to address this and other improvements resulting from suggestions from family members have been completed. The regular whanau meeting provides a forum for improvements.  Policies reviewed cover all necessary aspects of the service and contractual requirements, reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current, with a systematic and regular review process, referencing of relevant sources, approval and distribution occurring. The document control system is in transition from the intranet system to ‘Sharepoint’, with all policies transferred to the new system, and identified staff testing the new system at the time of audit.  The Quality Coordinator described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register was reviewed and showed the addition of newly identified risk (both organisation and service specific) and regular review. Regular reporting of risks to the Board occurs, as discussed with the CEO. The Human Resource Advisor takes overall responsibility for health and safety across the organisation; this is now a full-time role. This person is familiar with the Health and Safety at Work Act (2015) and requirements. There has been a strong focus on health and safety over the past 18 months. Risks have been identified and these were well displayed in the hospital area. |
| 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 document adverse and near miss events on a complaints, compliments and incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality team, Clinical Governance Group, and a summary to the Board. Categorising, Severity Assessment Code (SAC) rating, trending and analysis occurs with an array of graphs and data displayed for staff. The event management process was discussed with both the Quality Coordinator and Quality Facilitator. There has been no SAC 1 or SAC 2 events in the Hospital since the previous audit.  The Quality Coordinator described essential notification requirements, including for pressure injuries, and reported there had been two notifications related to a generator failure following a power outage (which has since been addressed), and a change of Board membership. |
| 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 | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of electronic staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained. The newly implemented electronic system has a check process to ensure all aspects of the process have been fully completed. Several volunteers work in the hospital area and undergo a similar appointment process.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three months and then annually. Volunteers have their own relevant orientation programme.  Continuing education is planned on an annual basis, including mandatory training requirements. Requirements have recently been reviewed and include yearly, two yearly, three yearly, and ‘one-off’ requirements specific to the needs of each clinical area. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The full 10 modules of the Fundamentals of Palliative Care are being offered over the course of the year, with good uptake from staff. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments.  Recording of training was occurring in two places at the time of audit, with a recent transition to a new electronic system completed. Until such time as managers feel comfortable with the new system, spreadsheets are also being maintained. The spreadsheet in the hospital was reviewed with the Clinical Nurse Manager and this showed, that with a few exceptions, all staff have completed mandatory training requirements, addressing a previous required improvement. Annual performance appraisals were current. Staff felt well supported with the array of training and professional development opportunities available. |
| 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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing includes registered nurses (RNs), enrolled nurses (ENs), hospital aides, an activities coordinator, physiotherapist, and physiotherapy aide. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Clinical staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a six-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. A casual pool of RNs, and ENs is available. There is 24 hour/seven days a week RN coverage in the hospital. |
| 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 | Medication management policies and procedures have been reviewed, are easy to follow, reflect legislative requirements and are consistent with the Medicines Care Guide for Residential Aged Care.  An electronic medicine system is contributing to the implementation of a safe system for medicine management and this was observed in operation. The system ensures good prescribing practices are upheld as an alert will come up if a required aspect of an entry is not completed. Three monthly GP reviews are evident within the electronic system. There is no verbal order or standing order system in place as a result of the electronic prescribing system.  Registered nurses and enrolled nurses administer medicines in this facility and those observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All of the nurses have completed competencies to perform different aspects of medicine management such as for administration, insulin administration and syringe driver use, as appropriate to their level of training and registration.  Medications are supplied to the facility in pre-packaged blister format from a contracted pharmacy. A registered nurse checks the medicines against each prescription when they arrive at the facility and signs this off in the residents’ files using a blue sticker to indicate the action. All medications sighted were within current use by dates. Pharmacist input is provided every two weeks when the bulk of the medicines arrive at the facility.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of ongoing checks as these medicines are accessed from a stock cupboard elsewhere in the facility.  The records of temperatures for the medicine fridge were within the recommended range. All medicines are stored in a locked trolley in a locked medicine room.  No residents were self-administering any form of medication at the time of audit. Appropriate policies and procedures are in place if a resident wanted to and was able to self-medicate.  Any medication related error is reported through the incident reporting system and subsequently through the quality and risk management system. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Nurse Maude’s food services are prepared on site by an external contractor. The kitchen and food services are registered as using the Hazard Analysis and Critical Control Point (HACCP) quality control food safety programme. The expiry date for this certificate is 31 October 2017.  A dietitian audited the four weekly rotating autumn-winter menu in February 2017 and the report was sighted. The report states the menu has the potential to meet the nutritional needs of the residents and includes additional information on therapeutic diets for residents requiring food with modified textures.  Each resident undergoes a nutritional assessment on admission, which is reviewed at the six monthly multidisciplinary reviews (or more frequently if required). Food preferences and any special dietary needs are identified. Systems have been established to ensure these are accommodated and residents are weighed monthly to monitor progress. Trained volunteers make significant contributions in assisting residents with their meals. Residents are supported to have their meals at a time that suits them, which means meals may be delayed and reheated. Evidence of resident satisfaction with meals was verified during resident and family interviews.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Monthly audits of these systems are undertaken and reported according to the HACCP certification requirements. An infection control food service audit was also completed in December 2016. Food temperature monitoring is being maintained. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The issues raised for corrective action at the certification audit have been addressed as service delivery plans of five residents were reviewed and all clearly described the required support and interventions in a comprehensive manner. Personal goals were identified from the assessments and were pertinent to the individual’s needs. Relevant interventions were detailed against each goal and the residents’ files sighted were consistent. There were multiple examples of updates to the care plans reviewed both at review timeframes and as a person’s condition changed. Examples of short term care plans also described required actions to support healing. Family members confirmed they are consulted about the needs of their relative, especially when they enter the service. Residents expressed trust that they are getting what they need and did not feel anything was being overlooked. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents were well presented, calm and appeared comfortable in the positions they were in whether in their bed or up in a lazy boy chair. A handover that ensured staff were informed of any changes with residents, or of special needs such as appointments, was observed. Staff confirmed they use the residents’ care plans to guide their actions and observations throughout the day confirmed that the care being provided was consistent with their needs, goals and the plans of care. There was evidence that residents’ individualised needs were being accounted for. Residents and family members stated during interviews that they are all fully satisfied with the care and support being provided with comments from three people stating how much better this service is than previous experiences had been. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high quality. A range of equipment and resources was available and was in use. |
| 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 a trained diversional therapist who is about to complete the national Certificate in Diversional Therapy. A diverse range of creative activities were evident in the programme provided, which includes individual and group activities, regular events and community involvement.  A personal profile that includes a social assessment and history is undertaken when each resident is admitted to the Nurse Maude hospital. The information from this is used towards the development of the person’s activities plans. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents.  Each resident’s activity needs are evaluated every six months (or as required) alongside the multidisciplinary review of their overall cares. Residents and families/whānau are involved in this process. Residents interviewed confirmed they find the programme stimulating and relatives stated that even if they are not able to participate staff make the effort to ensure they can watch what is happening.  Activities are formally offered Monday to Friday. The documented programme is colour coded to demonstrate that a holistic approach is taken during programme planning. Programme plans are developed to cover two weekly intervals. Individualised attendance registers are also colour coded enabling the diversional therapist to see at a glance the level of involvement of a resident. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Six monthly (or as required) multidisciplinary evaluations are being undertaken and were evident in all residents’ files reviewed. Family and residents confirmed during interview that they are involved and expressed appreciation for the opportunity to be involved and to be permitted to contribute. Six monthly interRAI reassessment reports were in client files and there were examples of information transfer into care plans, which helped inform the evaluation processes.  Short term care plans are being developed for problems arising and examples of these included skin tears and infections. The short term care plans are being evaluated daily and the issue closed out once healing has occurred. An example of changes made to a resident’s long term care plan as a result of evidence obtained from short term care plans was for a person who had become an increasing falls risk and required additional supervision when mobilising.  The underlying issues related to the corrective action raised at the last audit about required changes identified in evaluation processes not being transferred into long and/or short term care plans were no longer evident as changes are consistently being made to long and/or short term care plans when required, whether or not a formal evaluation had been scheduled.  Resident care is evaluated on each shift and any changes are reported to a registered nurse who takes the relevant action. In the residents’ files that were reviewed, progress notes had been documented for most shifts with a minimum of once daily. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness for the hospital. |
| 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 criteria are based on symptom and laboratory analysis for urinary tract, skin and soft tissue, fungal, eye, gastro-intestinal and upper and lower respiratory tract. Infections are recorded and reviewed by the infection control coordinator each month, to identify any emerging trends or patterns. Data is collected across the whole organisation; however, information is maintained for individual services. There are low rates of infections recorded. Monthly surveillance data is collated, analysed and graphed. Information about infection rates is shared with staff at regular staff meetings. Graphs are produced that identify trends for the current year, and comparisons against previous years. There have been no infection outbreaks in the hospital since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | Organisational policies and procedures describe an enabler and the different types of restraint. They also detail the expectations of staff around minimising restraint use, as well as the assessment, monitoring, safe use and evaluation processes. Lap belts are currently used as enablers by two residents who choose to use then when being transported in wheelchairs to the local shopping centre. Documentation in relation to this was sighted for one person in their Te Ora (activity) plan. Staff spoke with were aware of the requirements for managing any use of restraint and have received training in de-escalation techniques.  A six monthly hospital restraint report (June 2016 – December 2016) that was provided to the quality and risk team was viewed, as was the restraint register  Overall the service provider actively minimises the use of restraint and implements practices such as lowering beds and increasing supervision to prevent its use whenever possible. However, one person uses two types of restraint, one of which is bed rails and the other a groin harness. Although these are both being used with decreasing frequency, especially the harness, there was evidence that the monitoring documentation for the use of bed rails as a restraint does not meet the organisation’s policies and procedures, or the requirements of the standard. This requires corrective action. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Click here to enter text |

# 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)** |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | The use of enablers was voluntary, however while reviewing documentation of restraint use during this unannounced surveillance audit, it was observed that the monitoring records for a person using bed rails as a restraint were not meeting all requirements. Records of restraint use are being signed off following each shift but these do not demonstrate what checks have been done, or when, and do not detail what actions such as position changes, or providing food or fluids, or other comfort measures have been taken and when.  Although consent and assessment for the use of a groin harness was also available on file for this person, the groin harness has reportedly not been used for many months and monitoring processes for use of this form of restraint had been archived. | The monitoring records for a person who has been assessed as requiring a restraint are being signed for at the end of the shift and do not reflect times of any interim checks and interventions, as required by the organisation’s policy and procedure and the restraint minimisation and safe practice standard. | Ensure that monitoring records for restraint use meet the requirements of Standard 2.2.3 and 2.2.4 of the restraint minimisation and safe practice standard.  180 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.

|  |
| --- |
| No data to display |

End of the report.