# Montecillo Veterans Home and Hospital Limited - Montecillo Veterans Home and 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 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](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:** Montecillo Veterans Home and Hospital Limited

**Premises audited:** Montecillo Veterans Home and Hospital

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

**Dates of audit:** Start date: 6 November 2017 End date: 6 November 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** |
| --- | --- | --- |
|  | 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

Montecillo Veterans Home and Hospital Ltd provides hospital (medical and geriatric) and rest home level care to veteran men and women and their dependants. The service provides care for up to 44 residents with 41 residents on the day of audit.

An acting chief executive officer (also chief financial officer) is currently managing the service. The current clinical manager position is vacant. Experienced registered nurses and care staff provide support. Family and residents interviewed spoke very positively about the care and support provided.

This unannounced surveillance audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included, the review of residents and staff files, observations, and interviews with residents, family, management, general practitioner and staff. Residents and families spoke positively of the service provided.

The service has addressed two of the seven shortfalls identified at the previous audit, relating to updating the open disclosure policy, and activity plans. There continues to be improvements required around: quality data analysis/feedback, contractual timeframes, interventions, medication management and first aid training. This audit identified further improvements required in relation to clinical management, wound care and neuro observation documentation, care plan evaluations and restraint evaluations.

## 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. |

Montecillo provides care in a way that focuses on the individual resident. A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## 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. |

Montecillo has a documented quality and risk management system. Quality activities are conducted. Corrective actions are developed and implemented. The service has an implemented health and safety programme. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education planner in place for 2017 and is being implemented. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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

Registered nurses are responsible for each stage of service provision. A registered nurse completes initial assessments, risk assessments, and long-term care plans within the required timeframes. Care plans are evaluated at least six monthly. The medication management system includes policy and procedures that follows recognised standards. Registered nurses and senior caregivers are responsible for administration of medicines and complete annual education and medication competencies. A qualified diversional therapist oversees the activity team and coordinates the activity programme for the rest home and hospital. The programme includes community visitors and outings, entertainment and activities that meet the individual and group preferences and abilities for each resident group. Residents and families report satisfaction with the activities programme. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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

The service displays a current building warrant of fitness. There are documented emergency management procedures.

## 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. |

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service had six residents using restraint (all hospital level care) in the form of bedrails and/or lap belts and two (hospital level care) residents using bedrails as enablers. Restraint includes the use of bedrails and lap belts. There is a restraint and enablers register. Staff receive training in restraint minimisation and challenging behaviour management. Competencies are also completed.

## 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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

## 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 | 10 | 0 | 2 | 7 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 2 | 7 | 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 procedure is provided to residents and relatives on entry to the service. The acting chief executive officer (CEO) maintains a record of all complaints, both verbal and written, by using a complaint’s register. Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility. Two complaints have been made since the last audit. The two complaints reviewed had documented evidence of appropriate follow-up actions and resolutions taken. One of the complaints was made through the Health & Disability Advocacy (HDA), which was investigated and followed-up with an HDA letter in August 2017 stating that the complaint was closed off and no further action would be taken. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Standard operating procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is an open disclosure policy that has been updated since last audit. Accident/incident forms and electronic records of incidents have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed for October and November 2017, identified family were kept informed. Five residents (four hospital and one rest home) and three family members (hospital) confirmed on interview that the staff and management are approachable and available. Staff were observed communicating effectively with residents. The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate | Montecillo provides care for up to 44 rest home and hospital (geriatric and medical) level care residents. On the day of audit, there were 41 residents, which included 16 rest home, and 25 hospital residents. There were no residents under the medical component and one rest home resident was on respite. All other residents were under the aged related residential care (ARRC) contract. All rooms at Montecillo are dual-purpose (rest home or hospital). The service is divided over two floors with 20 rooms downstairs and 24 rooms upstairs. There are currently 14 rest home residents and five hospital residents in the downstairs wing. The upstairs wing currently has 20 hospital residents and two rest home residents.  The service has a current strategic plan and a business plan for 2017. The business plan identifies the purpose, values and scope of the business. The quality and risk management plan April 2018–March 2018 outlines the quality goals, which are reviewed at the ethical and clinical advisory committee meeting and the heads of department meetings. The service is governed by a trust board, which has two divisions, a financial committee and the ethical and clinical advisory committee (ECAC). The ECAC meets two monthly and receives reports on all aspects of service delivery at Montecillo.  The CEO retired in December 2016. The chief financial officer (CFO) is the acting CEO. The acting CEO reports to the trust board meeting and the ECAC. The acting CEO is non-clinical. The clinical nurse manager role provides clinical oversight at Montecillo, however on the day of the audit the clinical nurse manager role was vacant due to the previous nurse manager leaving in October 2017. The vacant clinical nurse manager role is currently going through the recruitment process. The senior RN is currently helping by taking on the key duties of the vacant clinical nurse manager role.  The acting CEO has completed at least eight hours of professional development related to managing an aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | Montecillo has a documented quality and risk management system. The acting CEO oversees the quality programme. The quality programme includes goals for 2017. The previous year’s plan has been reviewed. Policies and procedures provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The open disclosure incident/accident policy was reviewed in September 2016 to ensure that it fully aligns with service practice (sighted). This previous shortfall has now been addressed. Staff confirmed they are made aware of any new/reviewed policies.  The ethical and clinical advisory committee meeting, the heads of department committee meeting and the senior management team receive reports on the progress of the quality programme. Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The staff meeting template includes headings relating to these items, however meeting minutes do not reflect that these have been routinely discussed and communicated to staff. An annual resident and relative satisfaction survey was conducted in August 2016. The survey has not been fully analysed, and results have not been reported back to residents or families. This previous finding has not been addressed. A 2017 survey has not been completed at this stage.  An internal audit programme covers all aspects of the service. The outcomes of internal audits are discussed with staff at the various meetings. Corrective actions have been developed and implemented for shortfalls in service identified. There is a health and safety programme in place including policies to guide practice. There are designated health and safety staff representatives. Current hazard registers have been developed for all service areas and are easily located for staff. Staff (four caregivers, two registered nurses and one chef) confirmed they are kept informed on health and safety matters at meetings. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |
| 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 | The service collects incident and accident information (link 1.2.3.6). Twelve accident/incident forms were reviewed (October and November 2017). There has been RN notification and clinical assessment completed in a timely manner; however, for four incident forms reviewed for resident’s unwitnessed falls with a head knock/injury, there was no documented evidence of neurological observation forms being completed (link 1.3.6.1). Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family had been notified of accidents/incidents where this has been requested. Management were aware of their requirement to notify relevant authorities in relation to essential notifications. |
| 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 | There are human resources policies to support recruitment practices. Five staff files including two RNs, two nurse aides and one activities coordinator were reviewed. The files contained relevant employment documentation; all five files did not have an up-to-date performance appraisal for 2017. Noting, they had not been completed in 2016. Current practising certificates were sighted for registered nurses and allied health professionals.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that new staff were adequately orientated to the service on employment. Employment documentation was evident in the sample of staff files reviewed. There is an education planner in place for 2017 and is being implemented. Two out of six RNs have completed interRAI training. The acting CEO has completed the interRAI management training. Staff complete competencies relevant to their role. |
| 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 staff rationale and skill mix policy which includes rostering and acuity levels. Sufficient staff are rostered on to manage the care requirements of the residents (link 1.2.1.3). There is one registered nurse on duty at all times. All 44 beds within Montecillo are dual-purpose beds. The service is divided over two floors with 20 rooms downstairs and 24 rooms upstairs. The downstairs wing is where the majority of rest home residents reside. There are currently 14 rest home residents and five hospital residents in the downstairs wing. This unit is run by a senior nurse aide (Monday to Friday) with support from the registered nurse who is located upstairs. The upstairs unit currently has 20 hospital residents and two rest home residents. Advised that extra staff can be called on for increased resident requirements.  The roster includes a registered nurse rostered on the morning and afternoon, and night shifts. The RNs are supported by four nurse aides (upstairs) and two nurse aides (downstairs) on duty on the morning shift; three nurse aides (upstairs) and one nurse aide (downstairs) on the afternoon shift (plus one additional short shift nurse aide from 4.30 pm to 8.30 pm) to assist with the evening resident meals and one nurse aide (downstairs) and one nurse aide (upstairs) on duty on the night shift.  Other staff include an activities coordinator, cleaners, laundry staff, and the chef and kitchenhands. Residents and relatives interviewed confirmed that staffing is adequate to meet the needs of the residents. |
| 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. | PA Moderate | The medication management system includes a medication policy and procedures, that follows recognised standards and guidelines for safe medicine management. All long-term residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly blister pack system. All medicines are stored securely when not in use. When new medicines are supplied from the pharmacy, the RN completes a verification check against the resident’s medicine order. Medication orders include indications for use of ‘as needed’ medicines. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurses and senior caregivers with medication administration responsibilities (medicine competencies for the registered nurses and caregivers were sighted).  Administration sheets are appropriately signed. Ten (six hospital and four rest home) medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was signed each time a medicine was administered by staff. Short-term medications included a finish date. This previous shortfall has been addressed. The previous shortfall around sliding scale insulin charting was not evidenced in current use. One nurse aide and one registered nurse were observed administering medications and followed correct procedures. There was one resident self-medicating and a competency was on file, however, this did not meet requirements. Residents/relatives interviewed stated they are kept well informed of any changes to their medications. Not all medication charts had been fully documented by the GP. Improvements continue to be required around the medication 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 | There is a fully equipped commercial kitchen and all food is prepared and cooked on-site. All kitchen staff have completed food safety training. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. The dietitian had reviewed the menu. All fridges and freezer temperatures are recorded daily on the recording sheet. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room. A tray service is provided to the upstairs residents via a hotbox and to resident rooms as required. All food in the freezer and fridge is labelled and dated.  All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents’ dietary needs are communicated to the kitchen staff. Special diets can be catered for and currently the kitchen is catering for a resident who has a nut allergy. Alternative meals can be accommodated if needed. Residents’ weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented. There is a cleaning schedule in place. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The initial care plan is developed in conjunction with the resident and family and includes needs as identified by the registered nurse, in consultation with staff. Long-term care plans of all permanent residents reviewed were individually developed with the resident and/or family. Residents and family members interviewed stated they were involved in the care planning process. Care plans reviewed were individualised for each resident, however not all interventions were documented as identified by the progress notes, assessments, GP notes and allied health reviews. The previously identified shortfall has not yet been addressed. Short-term care plans are in use but do not always reflect interventions required to manage the resident’s care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Service delivery is guided by the resident’s plan of care, and handovers between shifts. Care plans are goal orientated and reviewed at six monthly intervals (link 1.3.8.2). The nurse aides and registered nurses interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights are monitored monthly or more frequently if necessary. There are currently seven residents with wounds, including three hospital level care residents with four healing grade-two pressure injuries and three hospital residents with skin tears and one rest home resident with a surgical wound. All identified wounds had an assessment and management plan in place. There was evidence of input from the GP and the DHB vascular team.  Not all initial wound assessments fully documented the wound and not all were redressed as per the management plan. Short-term care plans for wounds did not all describe the short-term interventions required (link 1.3.5.2). Continence products are available, and specialist continence advice is available as needed. Nurse aids and RNs interviewed state there is adequate continence and wound care supplies. Monitoring charts were used, and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required. Residents and family members interviewed confirmed their satisfaction with care delivery. |
| 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 | There is one activities coordinator (qualified diversional therapist) employed for 35 hours per week, who, with assistance from an activities assistant and staff, is responsible for the planning and delivery of the individual and group activities programme. Group activities are provided in the large communal rooms, in seating areas, and outdoors in the gardens when weather permits. Festivities and theme days are enjoyed. Birthdays are celebrated, and special events are catered for such as special family events, wedding anniversaries.  The activities coordinator has the use of a car and can access wheelchair vans as required for planned outings. Resident and management meetings are held three monthly with activities on the agenda. This allows for resident feedback and suggestions on the activities programme. Meeting minutes are made available to the residents. On the day of the audit, residents were observed being actively involved with a variety of activities including external entertainers. The group activities programme is developed monthly, and a weekly plan is provided to all residents and posted on noticeboards. The group programme includes residents being involved within the community in social clubs, churches and schools.  The DT interviews each newly admitted resident on or soon after admission and takes a social history. The service delivery plan developed by the RNs three weeks after admission includes cultural, spiritual and social needs. In all files sampled an activities plan is developed by the activities coordinator with goals and interventions specific for each resident and the outcomes social histories and individualised resident interests. The previous shortfall has been addressed. The evaluations are written at least three monthly. There is a resident attendance record kept. A record is kept of individual resident’s activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. The service has its own van for transportation. Residents interviewed described van outings, musical entertainment and attendance at a variety of community events. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Residents are reassessed using the interRAI process at least six monthly or if there has been a significant change in their health status (link 1.3.3.3). Long-term care plans are then evaluated. There was documented evidence that care plan evaluations were current in four of four permanent resident files sampled. However, evaluations did not always document progress towards meeting goals. Care plan evaluations were signed as completed by the RN. The GP reviews residents three monthly or when requested if issues arise or their health status changes. The GP stated that the staff communicate appropriately. Not all short-term care plans reviewed had been documented for acute changes in health status (link 1.3.5.2). |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness, which expires on 23 August 2018. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | Registered nurses are trained in basic life support but not first aid. There is not always a qualified first aider on duty, therefore the previous shortfall continues to require addressing. Fire safety training has been provided. There is an electronic call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service has no rest home residents with either restraint or enablers. On the day of audit, the service had six residents using restraint (all hospital level care) in the form of bedrails and/or lap belts and two (hospital level care) residents using bedrails as enablers. All enabler use is voluntary. The resident files of two residents using restraint did not evidence three monthly reviews were completed (link 2.2.4).  There is a restraint and enablers register. Staff receive training in restraint minimisation and challenging behaviour management. Policy dictates that enablers should be voluntary and the least restrictive option possible. The staff interviewed are familiar with this. Restraint/enabler use is discussed at registered nurse’s meetings. The service has appropriate procedures to document for the safe assessment, consent, planning, monitoring and review of restraint and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | On the day of audit, the service had six residents using restraint (all hospital level care) in the form of bedrails and/or lap belts and two (hospital level care) residents using bedrails as enablers. The resident files of two residents using restraint did not evidence three monthly reviews were completed. |

# Specific results for criterion where corrective actions are required

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

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

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

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Moderate | The chief financial officer (CFO) is the acting CEO. The acting CEO reports to the trust board meeting and the ECAC. The acting CEO is non-clinical. The clinical nurse manager role provides clinical oversight at Montecillo, however on the day of the audit the clinical nurse manager role was vacant due to the previous nurse manager leaving in October 2017. The service is currently going through the recruitment process. The senior RN is currently helping by taking on the key duties of the vacant clinical nurse manager role. | At the time of the audit there was no fulltime clinical nurse manager employed to work with the acting CEO, who is non-clinical. | Ensure that there is a fulltime clinical nurse manager employed to meet with the required clause D17.4b in the aged related residential service agreement. Ensure HealthCERT and the DHB are aware of the vacant role.  60 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | Quality activities are conducted as part of the annual quality and risk management programme. Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The staff meeting template includes headings relating to these items, however meeting minutes do not reflect that these have been routinely discussed and communicated to staff. An annual resident and relative satisfaction survey was conducted in August 2016. The survey has not been fully analysed, and results have not been reported back to residents or families. This previous shortfall remains an area for improvement. | (i)There was no documented evidence that quality/health and safety/staff meetings included discussion around quality data trends analysis and what actions were required by staff; (ii) The resident and relative annual satisfaction survey was conducted in August 2016. The survey has not been fully analysed, and results have not been communicated to residents and families. | (i)Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any.  (ii) Ensure that the results of the annual resident and relative satisfaction survey are communicated to residents and families.  90 days |
| Criterion 1.3.12.1  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. | PA Moderate | All ten medication-administration charts sampled documented that all medication given was appropriately signed for. All regular medication was prescribed by the GP in a manner that meets legislative requirements. All ‘as required’ medications had an indication for use. All short-term medications evidenced start/stop dates. There were currently no residents on sliding scale insulin. For residents on regular insulin, documentation included the times to be given. There were shortfalls identified around medication documentation and management. | (i) One respite resident did not have a signed medication chart in use.  (ii) One self-medicating resident had a competency documented, however, this did not evidence dates.  (iii) Four of four opened eye drops did not evidence opening dates.  (iv) Three of ten medication charts did not evidence three monthly reviews. | (i) Ensure that all residents have a signed medication chart on file.  (ii) Ensure self-medicating residents evidence three monthly competency reviews.  (iii) Ensure all eye drops are dated when opened.  (iv) Ensure all medication charts evidence that the GP completes a review at least three monthly.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | There are policies and procedures in place to guide staff around timeframes for resident assessment, care planning and evaluation. All permanent resident files evidenced timely long-term care plans. Care plan evaluations had been completed 6 monthly. Resident files reviewed did not all evidence contractual timeframes being met. | (i)One hospital resident did not have an initial interRAI assessment documented within 21 days of admission. Two of four permanent resident files (one hospital and one rest home) did not evidence interRAI reassessments had been completed. (ii)Two of four permanent files sampled (one rest home and one hospital level of care) did not evidence the GP initial visit had occurred within contractual timeframes. | Ensure that assessments, activities care plans and initial GP visits are completed within the required timeframes.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All long-term resident files reviewed had a long-term care plan documented and had been reviewed and updated within the last six months. Interviews with nurse aides identified that they were aware of the care needs of the residents. Long-term care plans did not document all the care interventions needed for individual residents. Short-term care plans had been implemented for changes in health for two residents, but did not fully detail the required interventions. | Four of four permanent residents’ files sampled did not have all identified needs addressed:  (i) One hospital level resident did not have interventions for identified behaviours that challenge.  (ii) One hospital level resident had minimal interventions documented for challenging behaviour.  (iii) One rest home had instructions from the dietitian for monthly assessments of nutrition that were not documented as an intervention in the care plan. The resident had falls prevention interventions (including a sensor mat) which were not reflected into the long-term care plan. Progress notes evidenced recent acute deterioration in mobility and cognition, but changes to interventions were not reflected in either a short-term care plan or updated in the long-term care plan.  (iv) One hospital resident with a pressure injury did not have care interventions documented in either a short-term care plan or updated in the long-term care plan. | Ensure that care plans describe the care and support needed as identified by assessments, and reflect allied health interventions.  60 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 Moderate | Montecillo implements wound management plans for all wounds. Registered nurses document an initial assessment and a documented management plan including goals, dressing type and frequency of changes. Evaluations are documented on the management plan and in the resident’s progress notes.  The service collects incident and accident information. Incident/accident data is reported and monitored though staff meetings. Twelve accident/incident forms were reviewed (October and November 2017). There has been RN notification and clinical assessment completed in a timely manner, however, for four incident forms reviewed for residents’ unwitnessed falls with a head knock/injury, there was no documented evidence of neurological observation forms being completed | (i) Two of eight wounds did not fully document initial assessments.  (ii) Four of eight wounds were not documented as dressed in the required timeframes.  (iii) Twelve resident incident forms were reviewed. For four incident forms reviewed for residents’ unwitnessed falls with a head knock/injury, there was no documented evidence of neurological observation forms being completed. | (i) Ensure all initial wound assessments are fully documented.  (ii) Ensure wounds are dressed within documented timeframes.  (iii) Ensure that any unwitnessed falls with a head knock/injury have neurological observation forms completed.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | The registered nurses advised that they undertake a review of the long-term care plan at least six monthly; Long-term care plans were sited as completed; however, progress towards meeting documented goals was not always evidenced on the files reviewed. There was evidence in the medical notes that the GP assesses the resident with an acute change in health condition. | Evaluations did not document progress towards meeting documented goals in two (hospital level care) of four permanent files reviewed. | Ensure evaluations document progress towards meeting documented goals.  90 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Moderate | Emergency supplies are available. Staff interviewed were aware of what to do in the event of an emergency, however, there was not a qualified first aider on duty at all times. | The rosters viewed identified that qualified first aid staff were not available on duty 24 hours a day. | Ensure there is a staff member on duty at all times with a current first aid qualification.  60 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Low | Residents on restraints evidenced pre-assessment and approval process documentation on file. The process for implementing restraint included family agreement and GP approval with three monthly reviews and two hourly monitoring charts. Not all residents on restraint had three monthly evaluations documented. Staff interviewed were aware of the risks of restraint and had education | Two resident’s files on restraints were reviewed. Two of two resident files did not have documented evidence of three monthly evaluations | Ensure that three monthly evaluations are completed for residents on restraints  90 days |

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

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

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

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

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End of the report.