

Bupa Care Services NZ Limited - Liston Heights Rest Home & 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](#).

The specifics of this audit included:

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| Legal entity: | Bupa Care Services NZ Limited |
| Premises audited: | Liston Heights Rest Home & Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 26 April 2018 End date: 26 April 2018 |
| 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: | 63 |

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Liston Heights Rest Home and Hospital provides rest home, hospital (geriatric and medical) and dementia level care for up to 75 residents. On the day of audit, there were 63 residents. The care home manager and clinical manager are appropriately qualified and experienced. Interviews with residents and family member confirmed overall satisfaction with the care and service provided.

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

The service has addressed all five previous shortfalls identified at their previous audit, around EPOAs, care plan interventions, monitoring documentation and review of medication charts and restraint documentation.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Residents and family are well informed including of changes in resident's health. The care home manager and clinical manager have an open-door policy. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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. |
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The Bupa Group governs the facility. Bupa has a business plan in place and the facility operates a quality plan, which includes goals for the calendar year. Goals are documented for the service with evidence of annual reviews. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. An annual resident/relative satisfaction survey is completed. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvement. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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. |
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Assessments, care plans and reviews are completed by the registered nurses within the required timeframes. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medications are

prescribed and stored appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Snacks are available in the dementia unit. Residents' records reviewed provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly.

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. |
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The building has a current building warrant of fitness.

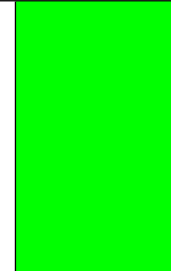
Restraint minimisation and safe practice

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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. | | Standards applicable to this service fully attained. |
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The service has restraint minimisation and safe practice policies and procedures in place. At the time of audit there were two hospital residents requiring the use of a restraint and no residents using an enabler. Staff receive training around restraint minimisation and the management of challenging behaviour.

Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control coordinator is appropriately trained. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 19 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 42 | 0 | 0 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>Five of five long-term residents' files reviewed indicated that decisions relating to care and welfare were undertaken by those legally entitled to make the decisions. This previous finding has now been addressed. All five files reviewed included resuscitation orders/advance directives that have been completed as per policy. Where a medical decision not to resuscitate by the GP has been made, there is documented evidence that the family/EPOA have been informed.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p> | FA | <p>There is a complaints procedure to guide practice. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. Discussion with residents and family members confirmed they were provided with information on the complaint process. Complaint forms were visible for residents/relatives in various places around the facility. The care home manager has overall responsibility for managing the complaints process at Liston Heights. A record of all complaints per month had been recorded on the register. The register included relevant information regarding the complaint, including date of resolution. There have been five complaints</p> |

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| <p>understood, respected, and upheld.</p> | | <p>made in 2017 and the two complaints received in 2018 year-to-date. All the complaints reviewed were investigated and any corrective actions required have been followed-up and implemented. Complaints are reported to head office monthly.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Ten accident/incident forms reviewed for April 2018 identified family were kept informed. Three family members (two hospital and one rest home) interviewed, stated that they are kept informed when their family member's health status changes. Resident/relative meetings are held every three months. Five residents (two hospital and three rest home) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. An introduction to the dementia care unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>Liston Heights Rest Home and Hospital is a Bupa residential care facility. The service is certified to provide care for up to 75 residents at hospital (medical, geriatric), rest home and dementia level care. On the day of the audit, there were 63 residents. There were 21 hospital residents and three rest home residents in the 32-bed hospital wing, including two residents on younger persons with disabilities (YPD) contract. (All 32 rooms in the hospital wing are dual-purpose). There were 30 rest home residents in the 31-bed rest home wings including two residents on respite care. There were nine residents in the 12-bed secure dementia wing. All other residents were under the aged related residential care (ARRC) contract. The rest home services are delivered across two floors.</p> <p>A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and provided to the Bupa clinical service improvement team on the progress and actions that have been taken to achieve the Liston Heights quality goals. Liston Heights is implementing three goals in 2018, one national goal (health and safety) and two facility specific (reducing falls and preventing pressure injuries). Progress to meeting these goals is reviewed at every quality meeting and a progress report documented quarterly.</p> <p>The service is managed by a care home manager who is a registered nurse. The care home manager has been in the role for three years. She is supported by a clinical manager who has been in the position for three months and has been in various nursing roles at Bupa for 20 years. The management team is supported by two unit-coordinators and a regional operations manager.</p> <p>Care home managers and clinical managers attend annual forums and regional forums six monthly. The care home manager has maintained at least eight hours annually of professional development activities related to managing a</p> |

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| | | hospital. |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule.</p> <p>Quality and risk data, including trends in data and benchmarked results are discussed in monthly staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. Riskman has been implemented by Bupa, which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries, falls, category one incidents are completed on the online system. Reports are automated and further analysis is completed of those reports. Liston Heights reports, analysis and consequent corrective actions were sighted. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Quality and risk data is shared with staff via meetings and posting results in the staffroom. An annual satisfaction survey is completed, and the June 2017 results demonstrated an 85% positive outcome. Corrective actions were established in areas identified as below the national average (i.e., around food services).</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer (care home manager) who is supported by health and safety representatives. The health and safety team meet monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed annually, last occurring on 16 March 2018. Bupa belongs to the ACC partnership programme and has attained their tertiary level (expiry 31 March 2018). Strategies are implemented to reduce the number of falls, this includes ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p> | FA | <p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team</p> |

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| <p>unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>immediately, and the regional operations manager. Actions are then followed-up and managed. Ten accident/incident forms were reviewed across the three service areas (four hospital, four rest home and two dementia). Each event involving a resident, reflected a clinical assessment and follow-up by a RN. Incidents are benchmarked and analysed for trends. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit. One resident absconding in April 2018.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical manager, one unit coordinator/RN, one enrolled nurse (EN), two caregivers and one activities officer) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. There is an annual education and training plan in place that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction.</p> <p>Seventeen caregivers are employed to work in the dementia care unit with eleven having completed their national dementia qualification. The six caregivers are in the process of completing their qualification and have all commenced work within the last 12 months. Registered nurses are supported to maintain their professional competency. Fourteen RNs are employed and twelve have completed their interRAI training. The care home manager and clinical manager are both interRAI trained. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for RNs including insulin administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and medication competencies.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p> | <p>FA</p> | <p>The staffing levels meet contractual requirements. The care home manager and clinical manager are available during weekdays and are on-call after hours with other RNs. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers' support the unit coordinators and RNs. Staff interviewed advised that there are sufficient staff on duty at all times.</p> <p>In the hospital unit (Liston and Tauhara wings), there were 21 hospital residents and three rest home residents. On the morning shift, there is one RN on duty on the morning and afternoon shifts and one on the night shift. The RNs are supported by four caregivers on the morning shift, five on the afternoon shift and one caregiver on the night</p> |

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| <p>qualified/skilled and/or experienced service providers.</p> | | <p>shift.</p> <p>In the rest home unit (CA1 and CA2 wings) there were 30 rest home residents. On the morning shift there is one-unit coordinator on duty, who is supported by three caregivers on the morning and afternoon shifts and one caregiver on the night shift. In the Ngauruhoe dementia unit, there were 9 of 12 residents. On the morning shift there is one-unit coordinator on duty, who is supported by two caregivers on the morning and afternoon shifts and there is one caregiver and on the night shift. On the afternoon and night shifts there is one RN from the hospital unit that covers across the rest home and dementia units. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering medications at the time of audit. The service uses robotic packs and an electronic medication management system. The RN checks all medications on delivery against the medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are securely and appropriately stored in the nurses' station in the rest home and dementia units, and in the treatment room in the hospital. The medication fridges have temperatures recorded daily and these are within acceptable ranges.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders used were appropriately reviewed and documented by the respective general practitioners.</p> <p>Ten medication charts were reviewed. Photo identification and allergy status were on all charts. All medication charts for long-term residents had been reviewed by the GP at least three-monthly and signed either on the review section of the medication chart or through GP notes. Ten of ten medication charts audited evidenced that medication reviews had been undertaken at least three monthly. The previous finding relating to medication reviews has been addressed.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p> | <p>FA</p> | <p>The cook oversees the food services and is supported by another qualified cook and two kitchenhands. The national four weekly rotating seasonal menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site in the main kitchen. Meals to the main hospital dining room are served directly from the kitchen and meals to the rest home and dementia units are delivered to the respective kitchenettes in hot boxes to be placed in bain maries for serving. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated.</p> |

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| <p>and nutritional needs are met where this service is a component of service delivery.</p> | | <p>Snacks are available for residents in the dementia unit 24/7 and in the rest home where a diabetic resident requires access to snacks.</p> <p>End-cooked food temperatures are recorded on each meal daily. Serving temperatures from bain maries are monitored. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods in the chiller, fridges and freezers are dated. Dry goods are stored in dated sealed containers. Chemicals are stored safely, and cleaning schedules are maintained.</p> <p>Food services staff (with the exception of the staff member currently orientating) have completed food safety education and chemical safety education.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>Overall the five long-term and one respite resident care plans reviewed were resident-focused and individualised. Care plans are templated and then personalised to reflect the current needs of the residents. One file was identified as having a high risk for pressure injuries. Interventions were documented around pressure injury preventions including the use of the recently purchased pressure relieving equipment. Medical conditions were identified as part of the care plans reviewed and included interventions. Files included STCPs documented for acute health changes such as (but not limited to) incidents/infections/ changes in treatment following GP visits, wounds and weight loss. STCPs were well documented and utilised for acute changes in health status. Previous partial attainments relating to care planning meeting resident's needs, monitoring of residents and medication reviews have now been addressed</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>The registered nurses complete care plans for residents. Progress notes in all six files sampled had detailed progress which reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>On the day of audit, there were four rest home residents with wounds (one skin tear, cellulitis, an ulcer and a lesion). In the dementia unit, one resident had five skin tears (result of a fall), another, one skin tear and a third resident had a podiatrist dressing to an ingrown toenail following treatment. For hospital level, there was one resident with a grade 2 pressure injury (healing) and other wounds for hospital level care included bruises, skin tears, an ulcer and a surgical incision. All wounds had an assessment, management plan and evaluations. Stocks of continence and dressing supplies are monitored by the RNs and ordered on a regular basis.</p> <p>Sufficient continence and dressing supplies are available. Registered nurses were able to describe access for wound and continence specialist input as required. Monitoring forms in use (sighted) include; monthly blood pressure and weight monitoring, two-hourly turning charts, and behaviour monitoring charts. At the previous audit,</p> |

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| | | <p>visual checking of resident charts had not been completed for residents at risk of absconding. The resident had been reassessed and placed in a secure environment. Monitoring forms were in place and being completed (an example being repositioning). There were no visual check monitoring charts in use at time of audit as there were no residents currently requiring this level of monitoring. The purchase of additional pressure injury risk reducing equipment and the inclusion of its use in the care plans has addressed issues raised at the previous audit. This previous finding has now been addressed. Residents and families interviewed, reported their needs were being met. There was clear documented evidence of relative contact following GP reviews, incidents, infections, care plan reviews or any changes to resident health status.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The service employs a diversional therapist as the main activities coordinator and she is supported by three activities coordinators. Two work six hours per day, four days on/four days off and two work four hours, four days on/four days off. Between them they provide an integrated programme for rest home, dementia care and hospital level of care resident's activities Monday to Sunday.</p> <p>On or soon after admission, the family/resident completes a 'Map of Life', which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated into the 'My Day My Way' care plan and is reviewed six-monthly as part of the care plan review/evaluation and a record is kept of individual residents' activities. Individual plans for residents in the dementia unit include activities/routines across 24/7.</p> <p>A monthly activities programme is given to all residents and a weekly programme is displayed on noticeboards throughout the facility.</p> <p>The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families (families are invited to meetings). Residents and relatives interviewed stated they feel the activities are good, and they are kept as busy as they want to be.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Care plans reviewed for long-term residents had been evaluated by registered nurses' six-monthly. There is a comprehensive six monthly multidisciplinary review documented. The multidisciplinary review involves the clinical manager, RN, GP (via documentation, they generally do not attend the meetings, but family are invited to meet the GP at the time of the three-monthly review), any allied health member involved in individual resident care, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and three-monthly GP review.</p> <p>Written evaluations describe the resident's progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six-monthly reviews.</p> |

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| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | The building has a current building warrant of fitness that expires 4 July 2018. Preventative and reactive maintenance occurs. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | There have been no outbreaks since the previous audit. |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. At the time of audit there were two hospital residents requiring the use of a restraint (one T belt and one bed rail) and no residents using an enabler. Restraint files reviewed included a restraint care plan and restraint monitoring was also documented in the progress notes. Staff receive training around restraint minimisation and the management of challenging behaviour. |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. A restraint register is in place, which has been completed for all residents using a restraint or enabler. Restraint use is reviewed through the three-monthly assessment evaluation, monthly quality meeting and six monthly multidisciplinary meeting and |

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| | | <p>includes family/whānau input. Restraint and enabler care plans are documented by the registered nurse and or the restraint coordinator. One resident was recently identified (within the week) as needing a restraint. A restraint assessment was completed and was in the resident's file. The restraint record was in the chart and restraint folder. This information was in the progress of being updated in the care plan.</p> |
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Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

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

End of the report.