# Presbyterian Support Central - Huntleigh Home

## 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:** Presbyterian Support Central

**Premises audited:** Huntleigh Home

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

**Dates of audit:** Start date: 7 November 2018 End date: 7 November 2018

**Proposed changes to current services (if any):** One resident room was assessed as suitable for a double dual-purpose room increasing the bed numbers from 71 to 72 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 67

# 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

Huntleigh Home is part of the Presbyterian Support Central organisation and provides rest home and hospital care for up to 72 residents. On the day of the audit, there were 67 residents.

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

The service is managed by a manager, who has been in the role 18 months and is a registered nurse. He is supported by a clinical nurse manager who has been in aged care for 11 years and in the role at Huntleigh for 7 months. The residents and relatives interviewed all spoke positively about the care and support provided.

Two of four shortfalls from the previous certification audit related to updating care plans and aspects of medication management have been addressed. Further improvements continue to be required around human resources and care plans interventions.

There were no new findings at this surveillance audit.

The service is commended for continued improvement ratings for activities and infection surveillance.

## 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. |

Policies are implemented to support residents’ rights, communication and complaints management. Family are involved in the initial care planning, provided health status occurs. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## 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 low risk. |

Huntleigh Home continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incident data, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The 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. |  | 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 provision of care. Assessments, care plans, interventions and evaluations have been completed within the required timeframes. Residents and family interviewed, confirmed that the residents’ needs/supports were being met. There is allied health professional input into the residents’ care.

Planned activities are appropriate to the residents’ assessed needs and abilities for rest home and hospital residents. Activities are varied, interesting and meaningful for the residents, as evidenced on resident/relative interviews.

Medications are managed and administered in line with legislation and current regulations. Registered nurses and senor healthcare assistants responsible for medication administration have completed annual competencies. The general practitioner reviews medication charts at least three monthly.

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

The facility has a current building warrant of fitness. There is a reactive and planned maintenance programme.

Call bells are responded to in a timely manner.

## 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. |

There is a restraint policy in place that states the organisation’s philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with any restraints and three residents using five enablers. Consents, assessments and evaluations had been completed as per policy. Restraint minimisation and enabler use training is included in the in-service training programme.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

The infection control nurse has overall responsibility for the monthly infection collation events. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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** | 1 | 14 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 2 | 39 | 0 | 1 | 1 | 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 | There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written). A complaint’s register records activity. Complaint forms are visible around the facility. Twenty-seven complaints (11 in 2017 and 16 in 2018 year-to-date) have been received since the last audit. The complaints reviewed were appropriately investigated and resolved to the satisfaction of the complainant, and any corrective actions identified were implemented. One of the complaints from 2017 was made through the DHB in September, which was followed up, investigated and closed off. One recent complaint in 2018 is still open and ongoing. In response to DHB pre-audit feedback, the auditors noted calls bells within proximity to the residents in all resident rooms, toilet/shower areas and communal areas. On the day of the audit call bells were responded to in a timely manner. There were no complaints made relating to call bell response times in any of the complaints reviewed for 2107 and 2018 year to date.  Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy. Six residents interviewed (five rest home and one hospital), stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed for October 2018, identified family were notified following a resident incident. Interviews with seven HCAs confirmed that family are kept informed. Two relatives (one rest home and one hospital) interviewed, confirmed they were notified of any changes in their family member’s health status. Resident and family meetings occur every three months. Enliven wide newsletters are produced on a regular basis. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Huntleigh Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital (geriatric and medical) level of care for up to 72 residents. On the day of the audit there were 67 residents in total; 41 rest home residents, including two residents on respite care and 26 hospital residents, including one resident on respite care and four residents on younger persons with disabilities (YPD) contracts. All 72 beds are dual-purpose. All other residents were under the age-related residential care (ARRC) contract.  Huntleigh Home has a 2018-2019 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden philosophy and health and safety. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior management team meetings.  The facility manager has been in the role since July 2017 with prior aged care management experience. The facility manager is supported by a clinical nurse manager and two clinical coordinators. The clinical nurse manager has been in the position since March 2018 and has worked at PSC for five and a half years. Management are supported by a regional manager who was present on the day of the audit.  The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| 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 | Presbyterian Support Central has an Enliven quality management system in place that includes internal benchmarking with the other PSC sites. There is an annual meeting schedule including senior team, staff, clinical/RN and health and safety meetings. The senior team meeting acts as the quality committee and progress with the quality programme/goals are monitored and reviewed through the alternate fortnightly senior team one and two meetings. Topics relating to internal audits, HR issues, CAP updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, restraint infection control, incident data, education/training and business plan goals are discussed. A range of other meetings is held at the facility as scheduled. Meeting minutes and reports are provided to the senior team meeting and actions are identified in quality improvement forms, which are being signed off and reviewed for effectiveness.  There is an internal audit calendar in place and the schedule has been adhered to for 2017 and 2018 (year to date). Monthly collation of accident/incident data and analysis is shared with staff (discussed at monthly staff meetings and placed on the noticeboard in the staff room). Corrective actions for any incidents above the benchmarking KPIs is reported to the senior team and clinical/RN meetings. The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service, ensuring staff are kept up to date with the changes.  The service has a health and safety management system, and this includes a health and safety representative (clinical coordinator) that has completed level three health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee meeting. There is an up to date hazard register which was last reviewed in May 2018.  A resident/relative satisfaction survey is completed annually. The October 2017 survey informed an overall satisfaction with the service at Huntleigh Home at 82.61% (relatives) and 73.33% (residents). Corrective actions were established in areas identified, followed up and completed, relating to the environment, social media, laundry, food service and activities. The 2018 resident/relative satisfaction survey results were not available at the time of the audit. Falls prevention strategies are in place and include intentional rounding, sensor mats, post-falls reviews and individual resident interventions. |
| 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 a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Twelve incident forms for Huntleigh Home were reviewed. All incident forms have been fully completed and residents reviewed by a RN. Neurological observation forms were documented and completed for nine unwitnessed falls or potential head injuries sampled. Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications completed since the last audit. A norovirus outbreak in July 2017 was notified to the public health authorities. |
| 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. | PA Low | There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. Six staff files reviewed (one clinical nurse manager, one clinical coordinator one RN, two HCAs and one recreational team leader), included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and orientation checklists. Huntleigh Home has 54 volunteers in total; 16 new volunteer files reviewed all had police and reference checks completed, and an agreement and orientation checklist in place.  The previous finding around the recruitment process of volunteers has now been addressed. However, missing was evidence of completed annual performance appraisals in staff files.  A copy of qualifications and annual practising certificates including RNs, general practitioners (GP) and other registered health professionals are kept. The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. There is an annual education and training schedule in place for 2018. The service provides regular in-service education and sessions have been provided that address all required areas. There are eight RNs and six are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager both work full-time from Monday to Friday. Registered nurses cover each 24-hour period in the hospital unit. Agency staff are used to provide cover for sickness if necessary. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents. Staffing levels are benchmarked against other PSC facilities.  The rest home and hospital units are on two levels. In the hospital unit (ground floor) there are 26 residents (17 hospital and 9 rest home). There is a clinical coordinator who works on Tuesday and Friday in that role and is supported by an RN on duty on the morning, afternoon and night shifts across 7 days. There are six HCAs (three long and three short shifts) on duty on the morning shift, five HCAs (two long and three short shifts) on the afternoon shift and one HCA on the night shift.  In rest home unit (upstairs) there are 41 residents (32 rest home and 9 hospital). There is an RN on duty on the morning and afternoon shifts. There are six HCAs (three long and three short shifts) on duty on the morning shift, five HCAs (two long and three short shifts) on the afternoon shift and two HCAs on the night shift. The hospital RN covers the rest home unit at night. |
| 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 | The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses who administer medications have completed medication competences and education on an annual basis. There are also HCA medication competent checkers. The service uses robotic rolls which are checked on delivery by a RN and date of checking entered into the electronic medication system. Medications are stored safely in the upstairs and downstairs medication rooms. There are monthly checks of the hospital stock and emergency supplies for expiry dates. Medication fridges are monitored weekly. All eyedrops in the medication trolleys had been dated on opening. There were no standing orders. There were no residents self-medicating.  Twelve medication charts (six hospital and six rest home) were sighted on the electronic medication system. All prescribing of regular and ‘as required’ medications met legislative requirements. The general practitioner reviews medication charts at least three-monthly. ‘As required’ medication was administered as prescribed and the effectiveness entered into the electronic medication system and progress notes. The previous finding around dating of eye drops and prescribing of eye drops and warfarin has been addressed. |
| 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 | All meals are prepared and cooked on-site in the main kitchen. The kitchen team leader is a qualified cook and is supported by a weekend cook and morning and afternoon kitchenhands. There is a five-weekly rotating summer menu in place that has been reviewed by a dietitian. Dietary requirements including vegetarian, gluten free and pureed meals (made in shaped moulds) are accommodated. The main meal is in the evening. Resident dislikes are known, and alternative foods provided. The chef receives resident dietary profiles and notified of any changes. Lip plates and specialised cutlery are available as needed. Meals are served from the bain marie in the kitchen directly to the residents in the downstairs dining room. Meals in bain marie dishes are transported to the upstairs dining room bain maire for serving.  The cooks and kitchenhands have completed food safety and hygiene training. The food control plan has been verified and expires July 2019. End-cooked and reheating temperatures are taken and recorded. The chiller and freezer are monitored with twice daily recordings. All dry goods in the pantry are dated. Cleaning schedules are maintained. Chemicals are stored safely. The chemical supplier conducts a chemical effectiveness check on the dishwasher monthly.  Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed, confirmed satisfaction with the meals provided. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | An initial plan of care was developed on admission for all resident files reviewed. Long-term plans and first interRAI assessments were developed within three weeks of admission. The RN progress notes document communication with the family regarding the development and review of care plans. Residents and relatives interviewed confirmed they are involved in the care plan process. The long-term care plans are updated as changes occur, following evaluations or routine interRAI assessments, however not all care plans reflected current supports required. The previous finding remains.  The care plans demonstrated allied health involvement in resident care. Each resident file sampled had a risk summary form at the front of their file detailing the resident’s medical problems and alerts such as high falls risk. Five of six care plans evidenced resident/relative input into care plan. The respite care resident has a support plan in place.  Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans reviewed had been evaluated at regular intervals and either resolved or if ongoing added to the long-term care plan. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition alters, a registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to): accidents/incidents, infections, health professional visits, changes in medications and challenging behaviours. Discussions with family members are documented in the health summary status notes and identified with a family contact stamp.  Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for four residents with current wounds including one resident (rest home) facility acquired stage two pressure injury of the heel. Photos demonstrated healing progress. Chronic wounds are linked to the long-term care plans. There is access to the DHB wound nurse specialist. The service has sufficient pressure injury equipment available and in use for high risk pressure injury residents.  Continence products are available and resident files included urinary continence assessment, bowel management and continence products identified for use.  Monitoring forms used include (but not limited to); blood pressure monitoring, behaviour charts, blood sugar levels, food and fluid, neurological observations, re-position charts, pain monitoring and monthly weights. |
| 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 service employs a recreational team leader (DT in training) and three recreational officers who coordinate the seven-day integrated programme. The programme allows for spontaneous activities to occur that reflect resident preference and meet the physical and cognitive abilities of both rest home, hospital and the younger people. There are the day guests who join in the programme as they choose. Volunteers are involved in assisting residents with their activities, provide music and one-on-one chats and discussions. They have discussions around collectables of yesteryear, assist residents with gardening in the courtyard and one volunteer is involved in the photo Christmas project. There are two recreational officers on each day to meet the differing needs of the residents. There are a number of lounge areas where activities are held. Resources are available at all times and placed about the facility to encourage individual or small group activities of choice. Themes and events are celebrated with Melbourne Cup and Diwali day in the month of November. Music therapy, arts and craft, quizzes, bowls, happy hours and Tai Chi exercises are included in the programme. There are regular outings in the van with wheelchair access for immobile residents. Community visitors include school children, SPCA dog therapy and volunteers. The trading post and men’s group have been successful resident-focused activities.  Each resident has an Eden “tree of life” in their resident file. The activity plan is based on companionship, usefulness, emotion, well-being and communication and is evaluated at the same time as the care plan. The activity assessments and plans for younger people reflect their individual hobbies and interests and links with the community.  The residents have an opportunity to feedback on the programme through resident meetings and surveys. Residents and families interviewed reported satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans of permanent residents had been evaluated by a registered nurse within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Reassessments have been completed using interRAI for residents who have had/required a change in level of care/significant change in health status. Short-term care plans reviewed evidenced they had been evaluated and either resolved or added to the long-term care plan if the problem is ongoing. Written evaluations document progress against the resident goals. Interventions are updated following any change identified through the 6-monthly care plan evaluation. The previous finding related to evaluation of care plans has been addressed. The resident/relative are involved in the care plan evaluations. The GP reviews the resident at least three monthly. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.  The MDT (multidisciplinary) meeting involves the RN, care staff, resident/relative, GP and any allied health professionals involved in the care of the resident. |
| 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 building holds a current building warrant of fitness, which expires 27 November 2018. There is a reactive and planned maintenance programme. The property manager confirmed all relevant legislative building checks had been completed for the upcoming building warrant of fitness. The facility was clean and free of odour.  One large, spacious resident bedroom was verified as suitable for a double room to accommodate a couple. Each resident had access to a call bell. The room had a full ensuite and privacy can be ensured. |
| 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. | CI | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Huntleigh. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of infections, trends and analysis including microbiology results, is completed on the GOSH register. Corrective actions for events above the benchmarking KPIs is reported to the senior management team and clinical meetings. The service had an influenza B and norovirus outbreak both in July 2017. Relevant authorities were notified and case logs and outbreak management documentation sighted. An action plan was put in place to reduce chest infections which has been successful. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. At the time of the audit there were no residents with any restraints and three residents using five enablers. Enablers are voluntary. Assessment and consent forms were evidenced in the three resident files reviewed using enablers. Restraint minimisation and enabler use training is included in the in-service training programme. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an annual education and training schedule in place for 2018. The service provides regular in-service education and sessions have been provided that address all required areas. Competencies are completed. There are eight RNs and six are interRAI trained. Missing was evidence of completed annual performance appraisals | Six staff files were reviewed, four of the six files did not have documented evidence of an up-to-date annual performance appraisal completed | Ensure that all staff files include a completed annual performance appraisal  90 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 | Care plans identified resident goals. Interventions for daily activities of living, medical problems and recreation are focused around promoting independence and wellbeing within the Eden philosophy of care. Three of five long-term care plans did not reflect the resident’s current health status. Interventions continue to be an area that requires improvement. | Not all interventions had been documented to meet the resident’s current health status for three rest home residents as follows; a) the long-term care plan had not been updated to reflect a pressure injury had healed and the resident was no longer self-medicating, b) there were no falls prevention interventions for high risk falls, and no interventions for the management of alcohol consumption as triggered in the interRAI and as per GP notes. Frequent urinary tract infections were triggered in the interRAI but not documented in the long-term care plan and c) there were no documented interventions for a resident with unintentional weight loss. | Ensure care plans reflect the current interventions to meet the resident’s needs.  60 days |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The Eden philosophy is implemented, and residents’ skills and abilities are celebrated and valued within the programme. Residents are encouraged to be actively involved in meaningful activities and resident-led projects, including the men’s group and the trading post. | The trading post is open on Mondays, Wednesdays and Fridays. It is set up in a lounge/café area, which is a popular room for coffee and snacks purchased from the trading post. The trading post is operated by residents. All proceeds from the trading post go towards a resident project which is the Christmas photo project this year. A men’s group was formed five months ago and facilitated by a male volunteer and the manager. The men in the group enjoy the men’s group get-togethers which are focused on discussions, fish and chips meals and bowls. The men decide which activities they would like to do, including outings to places of interest. Men interviewed confirmed they attend the group and enjoy the time spent with the manager and the volunteer. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | In 2017 there was an influenza outbreak and an action plan was implemented to reduce chest infections in 2018. There were 10 residents with influenza B in July 2017. The service has been successful in significantly reducing chest infections in 2018. | The service identified in the year of 2017, there were only 46% of staff who had influenza vaccines. A campaign was introduced to promote influenza vaccines for staff as well as increasing staff awareness around infection control practice. There were weekly videos on infection control prevention and management, staff education and resident education including reminders to use hand sanitiser at the dining room door. There was an increase of staff uptake of the influenza vaccine at 71% for 2018 with a result of one influenza like illness in June 2018 compared with 10 at the same time for 2017. |

End of the report.