

Maniototo Health Services Limited - Maniototo Health Service

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 Central Region's Technical Advisory Services 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:

Legal entity:	Maniototo Health Services Limited
Premises audited:	Maniototo Health Services
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 December 2018 End date: 12 December 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:	24

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

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

General overview of the audit

Maniototo Health Services Limited (Maniototo Health Service) provides care for up to 34 residents requiring rest home or hospital level of care. On the first day of the audit there were 24 residents residing at the facility.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board.

The audit process included review of policies and procedures; review of resident and staff files; and observations and interviews with residents, management, staff and a general practitioner.

Requirements for improvement from the previous partial provisional and certification audit relating to documenting verbal complaints in the register, neurological observations, recording staff designations on incident/accident records, general practitioner reviews, planned activities and 'as required medications' have been closed. Areas relating to: inclusion of verbal complaints in policy and medication reviews remain open.

There are additional areas requiring improvement at this audit relating to: supporting documentation for complaints; policy review; quality improvement data; essential notifications; adverse event reporting; appointment of appropriate staff; staff orientation, staff training and competencies; nursing notes and assessments; medical plans of care; short-term care plans; medicines management system; medication competencies, self-administration of medicines, restraint; and infection control surveillance.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Information on the complaints process is available to residents and their family. There is a documented complaints management system and a complaints register is maintained. Complaints are investigated and documented, with corrective actions implemented where required. There have been no complaint investigations to external agencies since the last audit.

Staff communicate with residents and family members following any incident and this recorded in the resident's file.

Residents interviews confirmed that the environment is conducive to communication, including the identification of any issues, and that staff are respectful of their needs.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Maniototo Health Service is governed by a board of directors. The mission, values and beliefs of the organisation are included in business planning documentation and made know to residents and their families on entry to the facility.

The organisation has a documented quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Quality policies are reviewed and current. Monthly business management reports are provided to the board. Incidents/accidents, infections, complaints and clinical indicators are monitored and reported to staff through meetings.

An internal audit programme is implemented. Corrective action plans are documented with evidence of resolution of issues when these are identified. There is a documented risk management plan and risks and controls are documented.

The facility is managed by an appropriately qualified and experienced general manager supported by two nurse managers. The nurse managers are registered nurses and are responsible for the oversight of clinical service provision.

Maniototo Health Service has human resource policies and procedures and newly recruited staff undertake orientation. Practising certificates for staff who require them are validated annually and ongoing training and education is provided for all staff members.

Rosters reflect the staffing requirements of the facility. Service delivery staff and resident interviews reported that there is adequate staff available.

Continuum of service delivery

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.
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The long-term care residents' initial nursing assessments and initial nursing care plans are completed by registered nurses within the required timeframes. Long-term care plans are individualised and record nursing interventions specific to the residents' assessed needs. Long-term care plans are reviewed six monthly. Where progress is different to that expected, the service responds by informing the general practitioner and medical reviews are conducted. Medical initial assessments and reviews are conducted within the required timeframe by the general practitioner.

Planned activities for long-term residents are provided in the rest home and the hospital. The activities are both planned and spontaneous. Activities focus on developing and maintaining skills and interests that are meaningful to the residents. The activity assessments and care plan reviews are completed within the required timeframes.

The service uses both electronic and hard copy medication charts. The electronic medication system was introduced to the rest home a day prior to this audit. Training and education had been provided to staff prior to this system being implemented.

The service has a contracted service provider for provision of food services. Residents interviewed were satisfied with the meal service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. There have been no structural alterations since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The restraint coordinator's role is shared by two nurse managers. On the day of the audit there were no residents requesting the use of enablers and four residents using restraint.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection coordinator's role is shared by two nurse managers. Surveillance for infections is undertaken monthly. The infection surveillance results are reported to staff and management.

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	6	0	5	5	0	0
Criteria	0	23	0	9	7	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The organisation's complaints/concerns management policy outlines the complaints procedure that is in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and includes the expected timeframes for responding to a complaint. The policy does not identify the process by which verbal complaints will be managed. This part of the previous requirement for improvement remains open. The complaint process and forms are made available as part of the information provided to residents and their families on entry to the service and available in prominent places throughout the facility.</p> <p>The GM is responsible for managing complaints. An up to date complaints register is in place that includes: the date the complaint is received; a description of the complaint; the investigation undertaken; resolution and the date the complaint is signed off. There had been two complaints documented on the register since the previous audit, including a verbal complaint. The part of the previous requirement for improvement relating to verbal complaints being documented on the register has been closed out.</p> <p>The complaints reviewed indicated that complaints are investigated promptly and issues are resolved in a timely manner. However, not all supporting information was available for each complaint.</p> <p>Staff and resident interviews confirmed that residents and family are able to raise any concerns and provide feedback on services. Residents stated that they were aware of a complaints process and how to make a complaint. Resident interviews confirmed an awareness of their rights to advocacy and how to</p>

		<p>access advocacy services, including in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy that sets out the process to guide staff to ensure that adverse, unplanned and untoward events are addressed in an open manner. Resident records demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded in residents' files and on the incident form (refer to 1.2.4.3). Resident interviews confirmed that family are informed of any changes in resident status and that family are invited to the care planning meetings for the resident.</p> <p>Quarterly resident meetings inform residents of facility activities and provide an opportunity to raise and discuss issues/concerns with management. Residents and family are advised of upcoming meetings and family are invited to attend the meetings verbally or by email. Minutes of the residents' meetings sighted evidenced that a wide range of subjects are discussed including but not limited to: progress on the new facility build; maintenance; upcoming events; and staffing.</p> <p>Residents and family have access to the minutes from these meetings and are also provided with copies of upcoming planned activities and the menu. Residents and families are also informed of updates and events through the local community newspaper. Resident interviews confirmed that the general manager (GM) and staff were available and responded promptly to any concerns raised.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. The policy provides staff with contact details for local interpreters. Residents are welcome to use family or others known to them as interpreters if they wish. At the time of the audit there were no residents who required interpreters.</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>	FA	<p>Maniototo Health Service's quality plan documents the organisation's mission, values and beliefs. These are communicated to residents and family as part of the information provided to new residents on entry to the facility. The organisation has a current business plan that outlines the strategic direction of Maniototo Health Service.</p> <p>The monthly management reports provide the board with progress against identified indicators.</p> <p>The facility has a GM who is supported by two part time nurse managers (NM). A general practitioner (GP) provides clinical leadership.</p>

		<p>The GM has been in the role for 12 years and has previous management and finance experience.</p> <p>The 2 NMs share the NM function providing a total of 0.6 FTE as NM, with identical job descriptions (refer to 1.2.7.3). One NM is responsible for clinical oversight for the hospital and the other clinical oversight of the rest home however, cover both areas when working at the facility on their own. The NMs work together one day per week. One NM has been working in the facility for thirty-two years, including fourteen of these years as an RN. The second NM has been with the facility as a RN for four years and is a qualified counsellor with previous experience in rest homes and as a nurse tutor. Both NMs have been in the role for less than one year and hold current annual practising certificates.</p> <p>The facility can provide services for up to 34 residents. The 34 beds are dual purpose beds. The facility is certified to provide hospital services - medical services; hospital services - geriatric services (excluding psychogeriatric); and rest home care (excluding dementia care).</p> <p>At the time of the audit occupancy included 12 residents requiring rest home level care and 11 residents requiring hospital level care. In addition, there was one resident assessed at hospital level care, under a younger person with a disability (YPD) agreement. The facility has contracts with the district health board (DHB) for the provision of: rest home and hospital level care; respite; palliative; YPD services and acute medical inpatients. There were no acute medical inpatients on the days of the audit.</p>
<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>	<p>PA Low</p>	<p>Maniototo Health Service has documented quality and risk management frameworks that are available to guide service delivery. All quality policies sighted demonstrated evidence of current review. However, not all clinical policies evidenced a current review; current document control; or reflect the appropriate legislation and practice guidelines.</p> <p>The GM reviews all policies with input from relevant personnel. New and revised policies are presented to staff at staff meetings and policy updates are also provided a part of relevant in-service education. Policies are available to staff in hard copy. Staff interviews confirmed that they are advised of new and updated policies.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators, including, but not limited to: incidents and accidents; surveillance of infections; pressure injuries; falls; medication errors and implementation of an internal audit programme. There is evidence that the annual internal audit programme is implemented as scheduled. Where required, corrective action plans are: developed; implemented; and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings.</p> <p>Quality improvement data is collected and collated. However, the identification of trends and analysis of data does not occur.</p>

		<p>Copies of meeting minutes are available for review in the staff room.</p> <p>The internal audit programme requires that annual satisfaction surveys for residents and families are to be completed. However, a resident and family survey has not been undertaken for 2018. Residents confirmed satisfaction with the services.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly.</p> <p>There are two nominated health and safety representatives and interview confirmed a clear understanding of the obligations of the role. Staff interviews confirmed an awareness of the process and responsibility to report hazards. There is evidence of hazard identification being completed and that hazards are addressed and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>The GM is aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. There have been no essential notifications to any other external agencies. Since the last audit one of the seven board members has been removed from the Company's Office register of directors and two new NMs have been appointed to job share the nurse manager role. However, only one NM has been notified to HealthCERT.</p> <p>A review of documentation confirmed that there is a process for staff to document adverse, unplanned or untoward events on an accident/incident form. Incident reporting forms are available in the facility. Documented incident forms included the designation of staff completing the form and evidenced that neurological forms had been completed for residents who had experienced an unwitnessed fall. The previous finding relating to adverse event reporting has been addressed.</p> <p>Staff records reviewed did not demonstrate evidence that staff had received training on the incident and accident reporting process (refer to 1.2.7.4). Staff interviewed understood the adverse event reporting process and their obligation to documenting untoward events. However, not all incident reporting processes are consistently completed.</p> <p>Corrective actions arising from incidents are implemented. Information gathered is shared at monthly health and safety meetings.</p> <p>Observation identified circumstances that could increase the risk of an accident and incidents.</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>PA Moderate</p>	<p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them.</p> <p>Human resource management policies and procedures meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrated that recruitment processes include: reference checks; police vetting; identification verification; position specific job description; and a signed employment agreement. However, not all human resource files reviewed demonstrated evidence of up-to-date police checks.</p> <p>An appraisal schedule is in place, however, not all staff have a current appraisal on file.</p> <p>There are two part-time RNs providing 1.2 FTE who have been appointed to share the NM role jointly providing a total of 0.6 FTE to this position. This does not meet the contract requirement of a full-time position of clinical manager.</p> <p>An induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks such as: personal cares; record keeping; and health and safety. Care staff confirmed their role in supporting and supervising new staff. However, interviews and staff files identified that the NMs have not undertaken and formal orientation specific to their NM roles.</p> <p>Staff records evidenced that ongoing education is provided. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of education and training hours per annum. However, the organisation does not have a documented, role specific mandatory annual education and training schedule.</p> <p>The two NMs and two other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies and most had completed CPR training. However, not all staff had completed the required training and competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service</p>	<p>FA</p>	<p>The facility currently has 52 staff consisting of: a management team; nine RNs, enrolled nurses; hospital aides; a diversional therapist; and household staff. Household staff include: cleaners; and kitchen staff; who along with hospital aides, provide household services seven days a week.</p> <p>The organisation's staffing levels and skill mix policy provides guidance to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Rosters are formulated two weeks in advance and staffing levels are reviewed to</p>

<p>providers.</p>		<p>accommodate anticipated workloads, identified numbers, and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>There are sufficient RNs and hospital aides available to safely maintain the rosters for the provision of care. There are also bath assistants who work short shifts at peak times and a pool of casual RNs available to supplement rosters when needed to accommodate increases in workloads and the acuity of residents such as additional hospital level residents. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy and demonstrated that there is at least one RN on each shift. Care staff have completed CPR training, however, none have completed first aid training (refer to 1.2.7.5).</p> <p>There is no on call roster, however, the GM is available for non-clinical matters and the RNs can be called after hours, seven days a week. The GP is on call for after hours and assistance is also available from Primary Response in Medical Emergencies (PRIME) nurses who are on-site on weekends and are available to provide primary response in a medical emergency.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Resident interviews stated that staffing is adequate to meet the residents' needs and staff confirm that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The service has implemented an electronic medication management system in the rest home on the day prior to the onsite audit. The hard copy medication charts continue to be used in the hospital and acute inpatient service. Allergies on the hard copy medication charts are not always recorded.</p> <p>The medications for the rest home and long-term hospital residents are supplied by the contracted pharmacist. Safe medicine administration was observed at the time of the audit. The drug register recorded weekly checks, however, six monthly stocktakes could not be evidenced.</p> <p>The medication refrigerator temperatures are monitored and recorded weekly and are within the recommended temperature range. The emergency trolley was observed not to be locked.</p> <p>The medication management policy requires review to include medication reconciliation and self-administration of medicines, and legislative references (refer to 1.2.3.3).</p> <p>Not all staff who administer medication have current medication competencies.</p> <p>The previous areas requiring improvements relating to 'as required medication' to record maximum doses and indication of use have been addressed. The part of the previous area requiring improvement relating to the residents' medication charts recording three monthly medication reviews remains open.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is contracted out to a private service provider. Food is transported to the facility, prepared and served by staff. The menus are reviewed by the service provider's dietitian. Spare meals, fresh fruit, baking and other foods are available for any acute admissions or for long-term residents if required. Residents reported satisfaction with the meals and fluids provided, however there has not been a satisfaction survey completed (refer to 1.2.3.6).</p> <p>Food temperatures are monitored appropriately and recorded. The kitchen cleaning schedules and equipment is maintained. Food in the chiller was covered and dated. The kitchen was clean and all food was stored off the floor.</p> <p>Not all staff who work in the kitchen have completed food safety and hand hygiene infection control education (refer to 1.2.7.5).</p> <p>Residents' food preferences and allergies are recorded and staff who serve the food are aware of these. Residents requiring assistance with meals are supported by staff, this was observed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>The nursing care plans are completed by the RNs and the NMs. There is evidence of residents and family input into the development of the nursing care plans. Care staff interviews confirmed they read and sign that they have read the nursing care plans and they are knowledgeable of the care requirements of the residents they are allocated to care for.</p> <p>The nursing care plan interventions were documented for the residents in both the rest home and the hospital. The care plans were individualised and personalised to meet the specific assessed needs of each resident. The residents reported satisfaction with the care and service delivery.</p> <p>There are regular and as required medical reviews conducted by the GP. Interview with the GP confirmed the clinical staff inform them of any resident's deteriorating or altered condition and medical reviews are conducted in a timely manner. There was evidence in the medical progress notes this is occurring. The nursing progress notes did not always record the resident's medical reviews (refer to 1.3.3.3). Review of the residents' clinical records and staff interviews confirmed the medical plans of care were not always implemented.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>There is a planned activities programme for both the rest home and hospital residents, which is provided from Monday to Friday each week. The monthly activities programme is developed by the diversional therapist. A daily activities programme is displayed in both rest home and hospital areas. The service has links with other community organisations, churches and local schools.</p> <p>Residents are free to choose whether they wish to participate in the activities provided. Residents are</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>encouraged to maintain links with the community through outings with family.</p> <p>Residents' attendance and participation is documented. Evaluations are completed six monthly with nursing review and there is evidence of resident and family participation.</p> <p>The diversional therapist completes residents' activities assessments and reviews the activities assessments and care plans six monthly. The activities care plans are completed by the diversional therapist or the RN with diversional therapist, resident and family input. Review of the activities care plans evidenced detailed and individualised activities relevant for the resident. The review of the YPD resident's file evidenced an appropriate activities care plan recorded. The previous requirement for improvement relating to residents' activities plans and their evaluation has been addressed.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Long-term care plan evaluations are conducted six monthly for the long-term rest home and hospital level care residents. There was recorded evidence of nursing care plan evaluations recording the degree of achievement to the interventions provided. For acute care patients evaluations occurred at each point of contact, as confirmed at staff interviews. Evaluation of care when there has been a change in the resident's condition is not always recorded in the progress notes (refer to 1.3.3.3).</p> <p>The short-term care plans are not always completed for short-term problems.</p> <p>There is evidence of referral to specialist services such as physiotherapy, nutritional, podiatry and specialist nurses where required.</p> <p>Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. Residents reported satisfaction with the care provided in each area of the service.</p>
<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>	<p>FA</p>	<p>The facility has a current building warrant of fitness. There have been no structural alterations since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with</p>	<p>PA Low</p>	<p>The infection control coordinator's role is job shared between the two NMs. There has been external training provided in infection prevention and control for the NMs.</p> <p>The infection prevention and control policies and procedures require review to align with the infection</p>

<p>agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>prevention and control standards. There was no recorded evidence of a policy on standardised definitions of infections or a policy on construction and renovation or an annual review of the infection prevention and control programme (refer to 1.2.3.3).</p> <p>The service conducts monthly surveillance for infections for the rest home, hospital, outpatients and the acute medical inpatient service. Review of the rest home and hospital residents' clinical records evidenced that the infections identified and treated did not always have a short-term care plan completed and were not included in the infection surveillance data (refer to 1.3.8.3). Interview with NM confirmed not all infection events required to be monitored for aged residential care were conducted.</p> <p>Infection surveillance is recorded, however, analysis and trends are not maintained (refer to 1.2.3.6).</p> <p>The ICN interviewed confirmed there had been one outbreak since the previous audit, however, the data relating to the outbreak could not be accessed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>The restraint's coordinators role is shared between the two NM. Interviews with staff and management confirmed this.</p> <p>Restraint minimisation and safe practice (RMSP) policy and associated documents require review to align with the RMSP standard (refer to 1.2.3.3).</p> <p>At the time of the audit the restraint register identified there were no enablers requested for use by residents and four residents were using restraints. The restraint/enabler assessment records include risks identified.</p> <p>Restraint minimisation is included in staff orientation/induction processes. However, the staff questionnaire for restraint competency requires review to align with the standard and not all staff have completed RMSP ongoing education and competencies (refer to 1.2.3.3 and 1.2.7.5)</p> <p>Restraint practices observed, interviews conducted with staff and management and review of documentation evidenced implementation of restraint use requires adherence to the RMSP standards.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>There is a current complaints/concerns management policy that identifies that complaints can be made verbally and a verbal complaint has been documented. The complaints process identifies the steps to be taken on receipt of a written complaint, however, it does not identify how a verbal complaint will be managed.</p> <p>In interviews residents stated that were satisfied that issues raised are dealt with effectively and efficiently. A complaints register is maintained. However, supporting information relating to each lodged complaint identified on the complaints register, to verify that the timeframes required where the code were met, was not consistently held in the complaints folder.</p>	<p>i) The process by which a verbal complaint will be managed is not documented in policy.</p> <p>ii) Supporting information is not available for each complaint.</p>	<p>i) Ensure the process for managing verbal complaints is documented in policy.</p> <p>ii) Ensure that all supporting information is maintained and available for each complaint.</p>

				30 days
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>The GM reviews all policies with input from relevant staff. Quality policies reviewed were current. However, not all available clinical policies reviewed were current or demonstrated effective document control.</p> <p>Quality policies are aligned with the Health and Disability Sector Standards. However, not all clinical policies consistently reflect the relevant legislation, Health and Disability Sector Standards or accepted good practice guidelines. For example, the medication policy, restraint policy and associated documents, and infection prevention and control policies.</p>	<p>i) Not all clinical policy/procedure documents demonstrated evidence of current review and document control.</p> <p>ii) Not all policies referenced the appropriate: legislation; standard; or guidelines.</p>	<p>i) Ensure that all documents evidence current document control and that out of date policies are removed from circulation.</p> <p>ii) Update policies and procedures to reflect current legislation; standards; and guidelines.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality improvement data is collected and evaluated. Residents and family are notified of updates through the facility's quarterly resident meetings. Quality is included in and discussed at staff meetings. Meeting minutes evidenced that quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. However, findings from quality improvement activities are not analysed or trends identified. It was not clear how specific learnings from quality activities, such as corrective actions from internal audits, are linked to quality improvement processes.</p> <p>Resident interviews confirmed satisfaction with the services provided. Resident and family survey had last been completed in 2017. The 2018 resident survey was overdue.</p>	<p>i) Quality improvement data is not analysed, trended or explicitly linked to the quality management system.</p> <p>ii) A resident and family survey has not been completed</p>	<p>i) Ensure that quality improvement data is analysed, trended and linked to the quality management system.</p> <p>ii) Complete the annual resident and</p>
				90 days

			for 2018.	family satisfaction survey. 60 days
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	The GM was aware of the circumstances which require the facility to report and notify statutory authorities. However, only one of two appointments of nurse managers had been reported to HealthCERT and the removal of one director had not been reported.	The appointment of one of two NMs and the removal of a board member had not been reported to HealthCERT.	Ensure that all notifications occur within the required timeframes. 30 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>A process is in place for the documentation of adverse events. Staff confirmed awareness of adverse event reporting processes. Incident reports selected for review evidenced that an assessment had been conducted, observations completed and there was evidence of a corresponding note in the resident's progress notes. Incident forms identified if the resident's family had been notified or that they would be notified, however, the incident form was not consistently updated to confirm when family had been notified.</p> <p>A review of resident notes identified that not all resident incidents had been documented on an incident form.</p> <p>Observations of auditors noted equipment (hoists) that had been certified as unfit for use and could still be accessed for use. Assurance could not be provided that equipment had not been used by staff. Floor surfaces observed require repair to reduce the likelihood of an accident or incident.</p>	<p>i) Notifications to family members were not always completed on the incident form.</p> <p>ii) Not all adverse events documented in resident files had been recorded and investigated in the incident reporting system.</p>	<p>i) Ensure that notifications to family members are updated on the incident form.</p> <p>ii) Ensure that all adverse events are documented and investigated through the incident reporting system.</p>

			<p>iii) Equipment that was unfit for use was available for use.</p> <p>iv) Floor surfaces were damaged or uneven.</p>	<p>iii) Ensure that all equipment that is unfit for use is not available for use.</p> <p>iv) Repair or make safe all uneven floor surfaces.</p> <p>30 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>Staff files reviewed demonstrated that recruitment processes include: reference checks; identification verification; position specific job description; and a signed employment agreement. Not all human resource files reviewed demonstrated evidence of up to date HR practices. Two of eight files did not evidence that a police check had been requested and/or completed. Four of eight staff files did not evidence a current performance appraisal.</p> <p>There are two part-time RNs providing 1.2 FTE who have been appointed to share the NM role jointly providing 0.6 FTE to this position. The aged-related residential care services agreement clause D17.4 ba. requires appointment to the full-time position of clinical manager.</p>	<p>i) Not all staff files evidence a police check.</p> <p>ii) Not all staff files evidence a current performance appraisal.</p> <p>iii) The 0.6 FTE NM does not meet contractual requirements.</p>	<p>i) Ensure all staff undergo a police check.</p> <p>ii) Ensure all staff have an annual performance appraisal.</p> <p>iii) Ensure the appointment of the clinical manager position meets contractual requirements.</p> <p>60 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>	PA Low	<p>Newly recruited staff complete an induction programme. The RNs sharing the role the role of NM received orientation on employment. However, the orientation was not specific to their roles as NMs.</p>	<p>Newly appointed NMs did not receive a documented</p>	<p>Ensure NMs receive a formal orientation that</p>

<p>orientation/induction programme that covers the essential components of the service provided.</p>			<p>orientation to their new NM functions.</p>	<p>includes the responsibilities of the NM role.</p> <p>60 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Staff records evidenced that ongoing education is provided and staff complete at least eight hours of training per annum. The facility is in the process of implementing a system to record and ensure annual competencies are completed. Staff records reviewed demonstrated not all staff had completed all required training and competencies including, for example, first aid, incident and accident reporting, infection control; moving and handling, or restraint. There was evidence food safety training and hand hygiene infection control education had not been completed by all kitchen staff.</p>	<p>i) An annual plan of training for all staff is not implemented. ii) Not all staff had completed training and competencies relevant to their roles.</p>	<p>i) Develop and implement and annual plan of training for all staff. ii) Ensure that staff complete training and competencies relevant to their roles.</p> <p>60 days</p>
<p>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</p>	<p>PA Moderate</p>	<p>The facility has implemented an electronic medication system in the rest home. The NM in the rest home was seen to be ensuring the correct process was implemented by staff.</p> <p>Visual observation evidenced the emergency trolley was accessible and not locked. The NM stated the trolley can be locked with the key that was hanging on the intravenous stand of the trolley. The trolley was locked on second day of the audit. There was no process in place to evidence who would have the emergency trolley key or where the key would be located for easy access.</p> <p>Review of the five hard copy medication charts in the hospital evidenced not all residents' allergies were recorded. Additional medication charts were reviewed to assess the non-conformity. Out of the additional 10 hard copy medication charts reviewed, 2 charts did not have allergies recorded. Discussion was held with the NM relating to the allergies not being recorded on the medication charts and this prompted for them to be recorded.</p>	<p>i) The emergency trolley was observed to be unlocked ii) Medication allergies are not always recorded on hard copy medication charts. iii) Medication charts do not evidence three monthly</p>	<p>Ensure the medication management system complies with legislation, protocols, and guidelines.</p> <p>30 days</p>

<p>legislation, protocols, and guidelines.</p>		<p>Review of the five hard copy medication charts in the hospital evidenced not all residents' medication charts indicated they have been reviewed by the GP three monthly. Additional medication charts were reviewed to assess the non-conformity. Out of the additional ten hard copy medication charts, three charts did not have three monthly medication reviews recorded.</p> <p>The current drug register evidenced weekly checks. The previous controlled drug register could not be located to evidence that six monthly stocktakes had occurred.</p> <p>Standing orders are reviewed annually by the GP. There was no evidence however of an audit of the standing orders being undertaken or that administered standing order medications had been signed off by the GP within the required timeframes.</p>	<p>reviews.</p> <p>iv) Six monthly stocktakes of drugs could not be evidenced.</p> <p>v) The management of standing orders does not comply with the requirements of the Medicines (Standing Order) Regulations 2012.</p>	
<p>Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>Hospital aides administer medicines in the rest home and RNs administer medicines in the hospital. The staff in the rest home have had training and education on the new electronic medication system that was introduced to the rest home one day prior to the on-site audit. Interview with the NM confirmed not all RNs and the NM have current medication competencies.</p> <p>There are standing orders used at the facility. They comprise of individual residents standing orders for the rest home and hospital residents and these are accessible to staff and reviewed annually by the GP. There is one folder of standing orders at the facility for the medical centre patients that may present to the hospital. These include not for resuscitation orders and individualised treatment plans for patients such as: migraines and anaphylaxis. There is a second standing orders folder for general conditions for acute patients presenting at the hospital. The general conditions standing orders exist for times when no GP or locum is available for immediate contact by the RN and immediate assessment and action is required by the RN prior to obtaining authority from outside sources. The standing orders guide actions of the RN, PRIME nurse or the medical centre practice nurse when faced with an acute presentation, while waiting for help or advice to arrive. There is no evidence the</p>	<p>Not all staff that administer medicines have current medication competencies, including standing orders.</p>	<p>Ensure all staff who administer medicines have current medication competencies, including standing orders.</p> <p>30 days</p>

		RNs on the ward have undertaken specific training and gained competency in being able to operate under the standing orders for general conditions. Interview with NM who operated under the standing order confirmed the standing order was followed for a specific condition for an acute patient presenting at Maniototo health services. A clinical record was maintained of this acute patient's assessment and treatment and this record was sent to the GM. There was no evidence the issuer of the standing order (the GP) had assessed the competency of the staff who are permitted to administer and/or supply medicine under the standing order (refer to 1.3.12.1).		
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	Review of the medication management policy evidenced the policy and guidelines relating to safe self-administration of medicines by residents is not included. This part of the policy was removed when the policy was last reviewed (refer to 1.2.3.3). Staff interviews confirmed there are residents who self-administer medicines at the facility. There was no recorded evidence of residents' assessments of competency to self-administer medicines.	Self-administration of medicines by residents is not completed as per current legislative requirements and safe practice guidelines.	Ensure residents self-administer medicines safely. 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	The hospital aides complete aged care daily notes on each shift in the rest home and hospital. These tick sheet notes include resident's information relating to: hygiene; elimination; food and fluid intake; activities; and reference to read progress notes if there has been an entry made. Review of the residents' progress notes evidenced the longest period of time with no written entry to be six weeks. One example of a rest home resident's progress notes entry: 16 March 2018 resident complained of abdominal pain; seen by GP; next progress notes entry 21 March 2018. Second example of a hospital resident's progress notes entry: 10 October 2018 entry by EN regarding the resident experiencing a cerebral event; next entry date 26 October 2018 entry by RN with records of another cerebral event; next date	i) Nursing progress notes are not completed in timely manner to provide recorded evidence of each assessment, event, visit, treatment, intervention,	i) Ensure nursing progress notes are completed in timely manner to provide recorded evidence of each resident's assessment, event, visit,

		<p>of entry 9 November 2018.</p> <p>Review of the rest home residents' clinical records evidenced the initial interRAI assessment were completed within the required timeframe. The hospital residents' clinical records evidenced the interRAI assessments were not always completed within the 21 days of the hospital resident's admission.</p>	<p>procedure and consultation for a resident and current information on the resident's care and condition.</p> <p>ii) The hospital residents' clinical records evidenced the interRAI assessments were not always completed within the required timeframe.</p>	<p>treatment, intervention, procedure and consultation for a resident and current information on the resident's care and condition.</p> <p>ii) Ensure the hospital residents' clinical records evidenced the interRAI assessments are completed within the required timeframe.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>The GP conducts initial medical assessments and reassessments in the required timeframes and when a resident's condition alters. The review of the medical progress notes evidenced regular and as required reviews by the GP. Detailed medical notes are provided following medical reviews and these include the medical plans of care, nursing observations and nursing care interventions that are required for the assessed condition.</p> <p>Review of the residents' nursing progress notes evidenced the medical plans of care are not always recorded in the nursing progress notes. There was evidence observations such as weekly weights, regular blood pressure monitoring and instructions for isolation of a resident were not implemented. Interview with the NM confirmed these had not occurred. Interview with the GP confirmed awareness of one event when weekly weight monitoring did not occur.</p>	<p>The medical plans of care are not consistently implemented.</p>	<p>Ensure the medical plans of care are implemented.</p> <p>30 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>Review of rest home and hospital residents' clinical records evidenced when a resident's condition altered the GP was informed and a medical review was conducted.</p> <p>The progress notes did not always record the change in condition or the updated medical plan of care (refer to 1.3.3.3 and 1.3.6.1).</p> <p>There was evidence when a resident's condition altered, a short-term care plan was not always recorded. This was evidenced in relation to: infections; skin tears; and change in medical condition.</p>	<p>Short-term care plans are not consistently completed for short-term problems.</p>	<p>Ensure short-term care plans are completed for short-term problems.</p> <p>90 days</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	<p>PA Low</p>	<p>Monthly surveillance of infection data is recorded.</p> <p>The standardised definitions of infections are not recorded and followed for the surveillance of infections for the long-term care residents at the facility.</p> <p>Review of data and residents' clinical records evidenced infections are not always recorded as part of the surveillance monitoring.</p>	<p>The surveillance of infections is not carried out according to the standard and the data is inaccurate due to not all infection being reported.</p>	<p>Ensure surveillance for infections is conducted according to the standards.</p> <p>180 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with</p>	<p>PA Low</p>	<p>Interviews with staff and management confirmed enablers would be used when requested by a resident as a voluntary means of promoting their independence and safety.</p> <p>There was equipment documented and used as restraint, such as sensor mat, that is not classified as restraint. Resident using bedsides as restraint did not have bedside covers. Monitoring of restraint is recorded on the daily check</p>	<p>Practices relating to restraint and enabler use do not align with the RMSP standards.</p>	<p>Ensure restraint and enabler use is implemented according to the RMSP standards.</p>

the intention of promoting or maintaining consumer independence and safety.		sheets and completed by filling in a tick box once a day on night duty.		180 days
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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.