# Athenree Lifecare (2016) Limited - Athenree Rest 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Athenree Lifecare (2016) Limited

**Premises audited:** Athenree Rest Home

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

**Dates of audit:** Start date: 2 April 2019 End date: 2 April 2019

**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:** 42

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Athenree Lifecare (2016) Limited, trading as Athenree Rest Home provides rest home, secure dementia care and hospital level care for up to a maximum of 43 residents.

The service is owned by private operators who have recently acquired another health service locally. Athenree Rest Home is managed by a facility manager who is a registered nurse (RN) and is supported by a senior registered nurse (RN) who has recently been appointed to the clinical nurse manager role. Apart from this, there have been no significant changes to the service and facilities since the previous audit.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, management, staff, the owner and a general practitioner. Residents and families spoke positively about the care provided.

Evidence of actions to rectify the three findings from the previous audit were assessed and all have been addressed. Three new findings were identified during this audit. These relate to activities in the dementia unit, staff appraisals and fridge temperature monitoring.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained and evidence that complaints are acknowledged, investigated and resolved promptly and effectively.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the operator is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

## Continuum of service delivery

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

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

There is a planned activity programme provided by an activities team that provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

There is a current building warrant of fitness and no structural changes to the facility have occurred since the previous audit.

## Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers in use and four residents were using bedrails as restraints at the time of audit.

## Infection prevention and control

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

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 3 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy and associated forms comply with Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to raise concerns or complaints. The complaints register and associated documents reviewed showed that the two complaints received over the past year were fully investigated, and actions were taken through to an agreed resolution within acceptable timeframes. The facility manger (FM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. One of these complaints submitted to the DHB in 2018 by a family about clinical care was fully investigated by the DHB. Remedial actions (staff training, review of staffing and consideration of the physical environment by a dementia expert) have been implemented. This was confirmed by interviews with the FM and the owner, telephone discussion with the DHB portfolio manager and documentation related to the matter. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their relative’s status, and that they were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by the records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | A two year Strategic Business Plan 2017-2019 with goals of the organisation is currently being reviewed. The plan outlines the purpose, values, scope, and direction. The document described annual and longer term objectives and links to associated operational plans. This is reviewed each time the owner visits on site. Interview with the owner confirmed that business goals and other operational matters are discussed. The FM is an RN with relevant qualifications. This person has been in the role for 15 months and has long term experience employed as an RN in other aged care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education and updates related to managers and clinicians. The service holds agreements with the DHB for age related care (ARCC) in rest home, dementia, hospital medical and geriatric care, respite and palliative care and with the MoH for Young People with Disabilities (YPD). On the day of audit 42 of the 43 beds were occupied. Fourteen residents were receiving hospital level care (two of these are under 65 years of age), 13 residents were receiving rest home care (two under 65 years) and 14 residents were in the secure unit. There was one additional resident on planned respite who was discharged on the day of the audit. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation is using a quality and risk system that reflects the principles of continuous quality improvement. This includes management and reporting of incidents and accidents, complaints, internal audit activities and monitoring of outcomes, regular resident and relative satisfaction surveys, and clinical incidents including infections.Documents reviewed confirmed monthly review and analysis of incidents, accidents and infections. Staff meeting minutes confirmed that this information is reported and discussed at each meeting. Staff reported their involvement in quality and risk management activities is via feedback at meetings. The FM coordinates a wide range of internal audits to be undertaken each year. Corrective actions are monitored and signed off when improvement is confirmed. A resident and family satisfaction survey is completed annually. Feedback from the most recent survey of residents about cleaning has been addressed. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The service provider/owner/operator is aware that most policies are about to come due for review and is looking for an overarching system that will address the needs in both health facilities. The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The current risk plan identifies all potential risks and describes methods for prevention, isolation or minimisation and there is a current hazard register. These meet legislative and contractual requirements. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at monthly staff meetings. Incidents of high risk are reported and discussed with the owner. The service is currently focused on reducing falls in the dementia unit (whilst avoiding restraint). A falls management programme, staff training and best practice interventions have had some success but falls are still occurring. A resident was returned from hospital after a fall in the night on the day of audit. The FM has submitted three Section 31 notices to the Ministry of Health (MoH). These relate to an unexpected death in August 2018, (which did not require a coroner’s inquest) the change of clinical manager in 2018 and a complex fall in October 2018 related to the complaint referred to in Standard 1.1.13, but this notice was returned by MoH. The FM and the owner said they had not been notified about any investigations by the Office of the Health and Disability Commission, nor any police investigations.A clinical matter referred to the DHB by a family member has been fully investigated, a number of corrective actions have been implemented and the complaint is now closed off. |
| 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 | Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Records reviewed confirmed that APCs for the RNs, GPs, pharmacist and physiotherapist are current and copies are retained. Job descriptions are attached to individual employment agreements in each of the staff files reviewed. There are specific role descriptions for the infection control coordinator and restraint coordinator.Staff orientation includes all necessary components relevant to the role. One new staff member reported that the orientation process prepared them well for their role and the staff records reviewed included proof of completed orientation. Continuing education is planned on an annual basis and includes mandatory training requirements, such as fire drills, restraint and infection prevention and control. Each of the six RNs and the EN have current first aid certificates and are annually assessed as competent to administer medicines. The FM keeps up with nursing knowledge and attends sector updates for managers of aged care facilities and written evidence was sighted of care staff attending in-service training sessions.There are four registered nurses trained and maintaining annual competency to undertake interRAI assessments, as is the FM. Confirmation of the cook having achieved unit standards 167 for safe food handling was sighted. Not all staff have engaged in annual performance appraisals. A corrective action is required in 1.2.7.5  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. A recent addition of two additional care staff ‘short shifts’ (one from 7am to 11am and the other from 6.45 am to 1pm) in the rest home and hospital area reflects the increase in the acuity and dependence needs of the current residents. Another care staff member had been rostered on in the secure unit, so there are two staff in attendance from 7am to 11pm for 14 residents. This was implemented to mitigate the number of falls in the unit subsequent to a complaint and input from a dementia specialist.An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff said that the addition of the two short shift personnel each day helped with allowing them to complete the work required. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided. There is an adequate pool of casual care staff to replace any unplanned absences. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage.It was noted that the activities staff hours’ in the secure unit are not always reliable or regular. Refer to corrective action in standard 1.3.7 |
| 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 policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range however regular temperature readings are not documented (Refer 1.3.13.5).Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.The previous audit identified an area for improvement to ensure that all residents self-administering medicines have had an assessment to review competency and all medications are stored securely as per policy. The corrective action is now addressed and records were available to demonstrate this. At the time of audit there was one resident who was self-administering medications. Appropriate processes were in place to ensure this was managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low | The food service is provided on site by a kitchen manager, two cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Western Bay of Plenty District Council which expires on 01 May 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan, however not all fridges have temperatures regularly recorded. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident’s nutritional needs, is available.Evidence of residents’ satisfaction with meals was verified from resident and family interviews and review of satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified that the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident. All residents admitted to the facility are orientated to the facility and assessed by the registered nurse in regard to mobility, transfers and the need for equipment. A referral to a physiotherapist is completed as required. Residents with a history of falling are discussed initially at registered staff meetings and interventions are implemented and care staff are notified. The ‘house doctor’ interviewed, verified that medical input is sought in a timely manner that medical orders are followed, and stated that the care provided is ‘good’. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | PA Low | The activities programme is provided by two activity co-ordinators, one of whom is training to become a diversional therapist. The activities team provides support from Monday to Friday 10.00 am to 4.00 pm. Activities for residents from the secure dementia unit are provided but the facility does not support residents in the dementia unit with dedicated activity hours. Currently the activities team does not have supervision from a trained diversional therapist. A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated three monthly and as part of the formal six- monthly care plan review. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings, day to day discussions with residents and family and satisfaction surveys. Residents interviewed confirmed they find the programme interactive and enjoy the regular van trips and visiting entertainment. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of working documents throughout the five residents’ files reviewed. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds and falls. A post fall assessment is completed for residents who have had a fall which includes a review of all daily activities of living. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness expiring in 03 December 2019 was sighted. Visual inspection of the interior and exterior of the facility revealed no issues. The building, plant and equipment are safe and in good working order. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the clinical services manager and reported to the facility manager and all staff. The facility has had a total of 41 infections since October 2018. Residents’ files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. There was evidence of over reporting of infections. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The FM who is the restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities. On the day of audit, four residents were using bed rails as restraints. Restraint is used as a last resort when all alternatives have been explored. This was confirmed by the files reviewed and from interview with staff. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | This was a previous non-compliance. Evidence that six monthly quality reviews have occurred in ways that meet the requirements in criterion 2.2.5.1 were sighted and the corrective action is now resolved. Documented quality reviews of restraint activity for the six month periods ending 09.04.2018, 07.11.2018 and 19.02.2019 contain information on the extent of restraint used, trends and in particular the cessation of restraint in the secure unit, no adverse events, review of the care and monitoring for each restraint in use, and staff compliance with protocols including requirements for staff education. |

# 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 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | A system for ongoing staff education is planned, documented and implemented. The topics covered are relevant to the care of older people.Three of the five staff files reviewed had no evidence of annual performance appraisals as required in the DHB agreement. One of the activities coordinators has not had a performance review since being employed in 2017. Policy also requires 90-day post-employment appraisals but these are not reliably occurring. | Staff performance appraisals are overdue. | Provide evidence that all staff are engaged in regular performance reviews.180 days |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The kitchen manager and registered nurse interviewed were aware of the food safety guidelines. Care staff stated that they check the fridge in the dementia unit and medication fridge daily. Temperatures are not recorded for the fridge in the dementia unit and temperatures have not being recorded regularly for the medication fridge. | Staff do not record temperature recordings for the fridge in the dementia unit. The medication fridge had not had a recorded temperature reading since the 31 January 2019. | Provide evidence of temperature recordings180 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Families confirmed their involvement in the assessment process and were happy with the care provided. Residents from the dementia area often integrate with rest home and hospital level care residents for van outings and visiting entertainment that is provided regularly at the facility. Resident’s files reviewed in the dementia unit all had a social profile, 24 activity behaviour clock and an attendance record of activities the residents participated in. The facility manager and activities team interviewed were not able to confirm what hours are dedicated to residents in the dementia unit. The activities team is not supervised by and/or have access to a trained diversional therapist for support. | The residents in the dementia unit do not have regular support from the activities team. Supervision is not currently available from a trained diversional therapist. | Ensure that residents in the dementia unit are provided with suitable and reliable activities which ensure diversion at appropriate times during the day. Provide a designated person such as a trained diversional therapist to supervise the activities programme and support the activities team to meet Aged Residential Care Contract (ARCC) requirements.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.

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| No data to display |

End of the report.