

# Montecillo Veterans Home and Hospital Limited - Montecillo Veterans Home and Hospital

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| <b>Legal entity:</b>  | Montecillo Veterans Home and Hospital Limited  |
| <b>Premises audited:</b>  | Montecillo Veterans Home and Hospital  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| <b>Dates of audit:</b>  | Start date: 8 May 2019      End date: 9 May 2019   |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 34   |



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

| Indicator | Description  | Definition  |
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| 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

Montecillo Veterans Home and Hospital Ltd provides hospital (medical and geriatric) and rest home level care to veteran men and women and their dependants. The service provides care for up to 44 residents with 34 residents on the day of audit.

A chief executive officer and a clinical nurse manager manage the service. Experienced registered nurses and care staff provide support. Residents and relatives interviewed all spoke very positively about the care and support provided.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, general practitioner and staff.

This audit has identified areas for improvement around informed consent, internal audits, incident reports, education, timeframes, care plan interventions, evaluations, monitoring, medications, restraint management, and infection control.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |
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Montecillo provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Residents and relatives interviewed verified ongoing involvement with community. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Montecillo is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted. Corrective actions are developed and implemented. The service has a culture of health and safety. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service

has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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| <p>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.</p> |  | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident, and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health. There is a three-monthly general practitioner review. Residents and family interviewed confirmed that they were satisfied with the care provided and the communication.

Planned activities are appropriate to the residents assessed needs and abilities and residents interviewed were satisfied with the activities programme.

There is a documented medication management system at the facility.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least seven days.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Restraint minimisation and safe practice policies and procedures are in place. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently three residents who require the use of a restraint and one resident who has requested the use of an enabler.

## Infection prevention and control

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| <p>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.</p> |  | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.



## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 37                  | 0  | 5                                    | 8  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 85                  | 0  | 7                                    | 9  | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>  | FA                | <p>Montecillo has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Six nurse aides, one activities coordinator, three registered nurses (RN), two enrolled nurses (EN) and the clinical nurse manager were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with five residents (two rest home and three hospital).</p>   |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | PA Low            | <p>Informed consent processes are discussed with residents and families on admission. Written consents were not all signed correctly. The six resident files (four hospital including one resident on an ACC contract and two rest home level care residents including one under a long-term chronic health contract) reviewed, demonstrated that resuscitation orders are signed for separately. There is not always evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Not for resuscitation orders are not always signed by the resident when medically competent to do so. Nurse aides, enrolled nurses and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All six resident files sampled had a signed admission agreement, however not all residents had signed consents.</p> |

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| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | <p>FA</p> | <p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Advocacy is discussed at resident meetings and information is available along with complaints forms and process. The advocacy service has visited the service recently and attended a residents' meeting and provided staff training. The resident files sampled included information on the residents' family and chosen social networks.</p> <p>Interviews with residents and relatives confirmed they were aware of their right to access advocacy and the service provides opportunities for the family/EPOA to be involved in decisions.</p>   |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirmed the staff help them access community groups.</p>   |
| <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>FA</p> | <p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The chief executive officer (CEO) leads the investigation of concerns/complaints with input from the nurse manager for clinical and care issues. Complaints forms are available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. Two complaints from 2018 and three from 2019 were reviewed including a Health and Disability Complaint.</p> <p>The Ministry requested follow up against aspects of the H&amp;D complaint that included reviewing the complaints process. There were no identified issues in respect of this complaint. Following the Health and Disability complaint, the facility have made the complaints form more user friendly, the investigation form was extensively changed to make a logical stepping process and include remedials. A "register of individual complaint with dates and actions taken" form has been developed as an easy reference of timelines and progress. Since the Health and Disability complaint, all complaints have been appropriately managed, with acknowledgement letters, letters of investigations conducted, and outcomes achieved provided to complainants within expected timeframes. The complaints register is up to date. Management operate an 'open door' policy.</p> |

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| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>  | <p>FA</p> | <p>There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health &amp; Disability (HDC) Commission. The hospital residents and relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the signed service agreements. Residents and relatives interviewed confirmed they received all the relevant information during admission.</p>   |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>                           | <p>FA</p> | <p>There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process, with family involvement. There are clear instructions provided to residents in their admission agreement on entry, regarding responsibilities of personal belongings.</p> <p>Staff have completed education around privacy, dignity and elder protection. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy and support residents in making choice where able.</p> <p>Resident files are stored securely.</p>   |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Montecillo has a Māori health plan. There is a cultural safety policy to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are addressed in the care plan. Links are established with community representative groups as requested by the resident/family. The facility has linkages with Iwi of Ngati Tumatauenga. A staff member from the sister site acts as cultural adviser. Cultural training has not been provided for staff, (link 1.2.7.5), however on interviewing staff they can fluently describe aspects of care to be mindful of, and the importance of whānau in the delivery of care for Māori residents. There was one resident that identified themselves as Māori on the day of audit.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>  | <p>FA</p> | <p>The resident and relatives are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents' needs are being met. Discussion with residents and relatives confirmed values and beliefs are considered. Residents are supported to attend church services of their choice.</p>  |

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| respect their ethnic, cultural, spiritual values, and beliefs.   |    |   |
| Standard 1.1.7: Discrimination<br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.              | FA | In the eight staff files sampled (clinical nurse manager, two RNs, three nurse aides, one activities coordinator, and one cleaner), job descriptions included responsibilities of the position and signed copies of all employment documents are included. Staff comply with confidentiality and the code of conduct. The RNs and allied health professionals' practice within their scope of practice. Interviews with the chief executive officer (CEO), the registered nurse and nurse aides confirmed an awareness of professional boundaries. Staff have completed questionnaires on professional boundaries.  |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an appropriate standard.  | FA | Montecillo policies and procedures meet the health and disability sector standards. Staff are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff reported that the registered nurses are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RNs have access to external training at the DHB. Discussions with residents and family were positive about the care they receive.   |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. The clinical nurse manager and registered nurses interviewed confirmed that family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Fifteen incident forms were reviewed, and all confirmed family were informed.<br><br>There is access to an interpreter service as required.   |
| Standard 1.2.1: Governance<br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of            | FA | Montecillo provides care for up to 44 rest home and hospital (geriatric and medical) level care residents. On the day of audit, there were 34 residents, which included 15 rest home, including one resident on a long-term support chronic health contract (LTS-CHC), and 19 hospital residents, including one resident on an ACC contract. All other residents were under the age-related contract. All rooms at Montecillo are dual purpose (rest home or hospital).<br><br>The service has a current strategic plan and a business plan for 2019. The business plan identifies the purpose, values and scope of the business. The quality and risk management plan outline the quality goals, |

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| <p>consumers.</p>   |                        | <p>which are reviewed at the ethical and clinical advisory committee meeting and the heads of department meetings. The service is governed by a trust board, which has two divisions – a financial committee and the ethical and clinical advisory committee (ECAC). The ECAC meets two monthly and receives reports on all aspects of service delivery at Montecillo. On the days of the audit, Montecillo was undergoing extensive building repairs to relevel the building. All residents, relatives and neighbours have been informed. Ten rooms have been closed for work to be undertaken. There is a staged plan and extensive health and safety plan in place.</p> <p>The chief executive officer (CEO) is non-clinical and has been employed by Montecillo for 20 years in various clerical roles, and has been in the CEO role for around a year. She reports to the trust board meeting and the ECAC.</p> <p>The clinical nurse manager (CNM) has previous experience in management, and has been in the role for a year, she provides clinical oversight at Montecillo. The clinical nurse manager has had three weeks off with the first day back being the day of the audit. The CEO was supported by the registered nurses in the CNM absence.</p> <p>The chief executive officer and the clinical nurse manager have completed at least eight hours of professional development related to managing an aged care facility.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p>              | <p>The clinical nurse manager provides cover in the absence of the chief executive officer, with support from the Montecillo office team and the registered nurses.</p>  |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>   | <p>PA<br/>Moderate</p> | <p>Montecillo has a documented quality and risk management system. The quality programme includes goals for 2019, and the 2018 plan has been reviewed. The CEO and CNM oversee the quality programme. Internal audits are not evidenced to be completed in 2018. There have been internal audits completed in 2019 with no formal planner. Areas of non-compliance have been identified, but there is no documented evidence of follow-up or sign off of completion. There is evidence in the 2019 meetings around internal audits completed.</p> <p>There is a trained health and safety officer who has level 3 training in health and safety. The health and safety</p>   |

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| <p>risk management system that reflects continuous quality improvement principles.</p>  |                        | <p>committee include a cross section of staff (two RNs, one kitchen, one administration, one housekeeping and laundry, CEO and CNM). The health and safety committee meet monthly. Montecillo collects information on resident incidents and accidents as well as staff incidents/accidents, and provides follow-up where required. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. Contractor management, as part of the health and safety programme, has not been implemented. Health and safety matters are discussed at the ECAC meetings.</p> <p>The ethical and clinical advisory committee meeting, the heads of department committee meeting and the senior management team receive reports on the progress of the quality programme. Meeting minutes sighted evidenced discussion around accident/incident data, health and safety, infection control, audit outcomes, and complaints and concerns. A resident and relative survey was conducted in September 2018, which identified less satisfaction around food and activities. The CEO arranged a meeting to discuss the menu with the residents and the kitchen staff. This has resulted in changes in the winter 2019 (about to be implemented) to accommodate the residents' requests and has been reviewed by the dietitian. Meetings were held around the activities plan, a new activities assistant has recently been appointed, and changes are being implemented to accommodate residents' suggestions and requests such as more van outings, and guest speakers. Results have been collated analysed and reported back to residents and relatives. The service collates accident/incident and infection control data. Meeting minutes, monthly data comparisons, trends and graphs are available for staff information. Staff who have not attended meetings sign a form when they have read the minutes. The nurse aides interviewed were aware of quality data results and trends identified.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents, however, there was no evidence on incident reports to identify interventions to minimise future falls (link 1.2.4.3).</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<br/>Moderate</p> | <p>A sample of 15 accident/incident forms from February to April 2019 were reviewed. There has been RN notification and clinical assessment completed in a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the relatives/NOK had been notified of accidents/incidents where this has been requested. Not all pressure injuries have incident reports documented, and opportunities to minimise risk has not always been identified.</p> <p>The service collects incident and accident data and reports statistics and trends identified to the ethical and clinical advisory committee, the clinical (RN) meeting, nurse aide meeting, health and safety meeting and heads of department meeting. Staff interviewed confirmed incident/accident data is discussed at the various meetings and information and graphs are made available.</p> <p>Discussions with the management team confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 forms were completed for the boiler replacement, a fire call out and building renovations.</p>  |

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| <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<br/>Moderate</p> | <p>There are human resources policies to support recruitment practices. Eight staff files sampled contained all relevant employment documentation and included one clinical nurse manager, two registered nurses, three nurse aides, one activities coordinator and one housekeeping. Current practising certificates were sighted for registered nurses and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that new staff were adequately orientated to the service on employment. Employment documentation was evident in the sample of staff files reviewed.</p> <p>There is an education planner in place for 2019 and is being implemented which exceeds the eight hours training required, however, not all contractual education has occurred. Four registered nurses have completed interRAI training. Staff complete competencies relevant to their role. One nurse aide has completed level 2 Careerforce with two nurse aids enrolled to complete, ten have completed level 3, and one nurse aide is enrolled, six nurse aides and one activities coordinator have completed level 4. There is a staff member on duty with a first aid certificate at all times.</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 providers.</p>       | <p>FA</p>              | <p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The chief executive officer and the nurse manager are on site full time and available after hours. The registered nurses are rostered on 24/7. The nurse aides, residents and family interviewed informed there are sufficient staff on duty at all times. Agency staff are used when required.</p> <p>The current roster as below is for the reduced capacity of ten beds due to renovations.</p> <p>1 x RN on each shift – am, pm and night covering both floors. There are two recently employed enrolled nurses (ENs) who support the RNs Monday to Friday mornings at present. Nurse aides are using a four on, four off roster.</p> <p>Upstairs (7 rest home and 14 hospital)</p> <p>Morning: 3 x 0645-1515; Afternoon: 2 x 1445-2315; 1 x 1630-2230; Night: 1 x 2300-0715.</p> <p>Downstairs (5 hospital and 8 rest home)</p> <p>Morning: 2 x 0645-1515 (one nurse aide assists upstairs for two hours in the morning and one hour over lunch). Afternoon: 1x 1445- 2315; 1x 1630- 2230 (and assists for half of the shift upstairs). Night: 1x 2300-0715.</p> <p>When the facility is running at full capacity (four more residents), there are four nurse aides upstairs in the morning, three long shift and one short shift in the afternoons. Downstairs (six more residents), there are two</p> |



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|   |             | <p>nurse aides on long shift in the morning, one long and one short in the afternoons.</p> <p>Plus, housekeeping staff; 2 x 0800-1500 Monday to Friday, 1 x 0800-1300 at weekends and holidays.</p> <p>Laundry; 1 x 0700-1400 seven days a week.</p>   |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>            | PA Low      | <p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant nurse aide or registered nurse, however designation was not consistently identifiable. Files are integrated.</p>   |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA          | <p>The service has comprehensive admission policies and processes in place. The clinical nurse manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Admission agreements were signed in all residents sampled records. Residents and families reported that the admission agreements were discussed with them in detail by the registered nurse or clinical nurse manager. All residents had the appropriate needs assessments prior to admission to the service. The service has specific information available for residents/families/EPOA at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>                            | FA          | <p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. A record is kept, and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service using the yellow envelope system. The registered nurse verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service.</p>  |
| <p>Standard 1.3.12: Medicine Management</p>   | PA Moderate | <p>Medication policies align with accepted guidelines. The RNs and nurse aides responsible for the administration of medications have completed annual competencies and medication education. A signed</p>   |

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| <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>  |           | <p>medication reconciliation form evidences medications are checked on arrival by the registered nurse. Any pharmacy errors are recorded and fed back to the supplying pharmacy. Standing orders were not in use. Medications requiring refrigeration are stored appropriately, however fridge temperatures are not consistently documented. Eye drops in current use were not always dated as required.</p> <p>Controlled medications are stored correctly. A weekly controlled drug stocktake is completed. Twelve electronic medication charts were reviewed. All medication charts had photo identification and allergy status. All charts evidenced three monthly GP reviews.</p> <p>The administration of medications observed during the lunchtime medication round complied with the medication administration policies and procedures. Current medication competencies were evidenced in the staff files.</p> <p>There were two residents who self-administered medications. The self-administration policies and procedures were in place.</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 service employs a qualified chef as the kitchen manager and all food is cooked on site. There is a food services manual in place to guide staff. A food control plan is verified with an expiry date of 30 September 2020. A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff. This document is reviewed whenever there is a change in the residents' nutritional requirements. The kitchen is able to meet the needs of residents who require special diets and the chef works closely with the registered nurses on duty. The kitchen staff have completed food safety training. The chef and cooks follow a six-weekly rotating seasonal menu, which was reviewed in January 2019 by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. A recent food survey and a meeting to discuss preferences is resulting in the implementation of menu changes. Residents and the family members interviewed were very happy with the quality and variety of food served.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where</p> | <p>FA</p> | <p>Montecillo Veterans Home &amp; Hospital records the reason for declining entry to potential residents should this occur and communicates this to potential residents/family/whānau and refers them back to the referral agency. The reason for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>   |

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| appropriate.   |             |   |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>                               | PA Low      | <p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The interRAI assessment tool is implemented and there are four RNs competent to use the tool. InterRAI assessments have been completed as required for all residents. Not all assessments were reviewed at least six monthly (link 1.3.3.3), or when there was a change to a resident's health condition. Not all resident files evidenced regular registered nurse reviews (link 1.3.3.4).</p>   |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>                       | PA Moderate | <p>The initial care plan is developed in conjunction with the resident and family and includes needs as identified by the registered nurse, in consultation with staff. Long-term care plans reviewed were individually developed with the resident and/or family. Residents and family members interviewed stated they were involved in the care planning process. Care plans reviewed were individualised for each resident, however not all interventions were documented as identified by the progress notes, assessments, GP notes and allied health reviews.</p> <p>Activities care plans were completed for five of six long-term files reviewed, one ACC did not have an activity care plan in place. Residents are seen by the GP at least three monthly or more frequently if required. The GP records progress in the medical records and 3-month reviews are documented on the resident's medicine management charts. Short-term care plans (or the long-term care plan updated) was not always completed for a change in health condition.</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> | PA Moderate | <p>Registered nurses and nurse aides follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the registered nurse will initiate a referral (eg, to the dietitian, physiotherapist or wound specialist nurse). If external medical advice is required, this will be actioned by the GP.</p> <p>Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described.</p> <p>On the day of audit, there were three wounds including one ulcer, one skin tear and one facility acquired grade 2 pressure injury. All wound documentation was fully completed. All wounds have been reviewed in appropriate timeframes.</p> <p>Interviews with registered nurses and nurse aides demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always demonstrate interventions to meet residents' assessed</p> |

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|   |        | needs (link 1.3.5.2). There was evidence of pressure injury prevention interventions such as turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management, however not all monitoring charts had been completed as documented in the care plan.   |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA     | <p>The activities coordinator works 72 hours a fortnight. She is assisted by a trainee working eight hours a week. The programme is planned over a five-day week and times vary according to the activity. The programme is planned monthly and additional activities are supported by the nurse aides. A volunteer supports the programme on a daily basis. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities such as visits to RSA group activities, lunch outings and assisting in the sale of poppies for Anzac Day. Residents and family interviewed confirmed participation is voluntary.</p> <p>Activities assessments and care plans are documented. Individual activities care plans and goals are documented. A record of individual attendance at activities is documented. Residents were viewed participating in activities during the audit. Not all residents had the activities care plan reviewed against the identified activities goals or within the required timeframes (link 1.3.3.3).</p> <p>Resident meetings and the next of kin survey provide a forum for feedback relating to activities as well as resident verbal feedback. Residents and family members interviewed were satisfied with the programme.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | PA Low | <p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were not all evaluated at least six monthly or earlier if there was a change in health status. Three residents had not been at the facility for six months and did not require a six-monthly review. Not all changes in health status were documented and followed up (link 1.3.5.2). Not all reassessments had been completed using interRAI LTCF for all residents who had a significant change in health status, such as a pressure injury (link 1.3.4.2). The registered nurse completing the care plan signs the care plan reviews. Short-term care plans sighted were not always evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p> <p>The family are notified of GP visits and three-monthly reviews by phone call and are informed of changes.</p>  |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>   | FA     | <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. Internal referrals are facilitated by the RN.</p>   |

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| <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>  |           |  |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>All chemicals were securely stored. Storage areas both inside and outside were locked. Chemicals were clearly labelled, and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required. Review of staff training records and interviews with nurse aides, laundry and cleaning staff confirmed that regular training and education on the safe and appropriate handling of chemical and waste and hazardous substances occurs. The chemical supply company visits each month to check that supplies are adequate, and that staff are managing chemicals safely and efficiently. Waste management systems meet legislative requirements.</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>Montecillo holds a current warrant of fitness, which expires 23 August 2019. The building is a two-level facility situated on level ground. The facility is modern, and purpose built, however there is evidence of significant cracking in the walls of some areas. After a prolonged process identifying cause and restoration strategies, repairs are now underway. Planning involves a timeline with identified actions and responsibilities including relocation of resident rooms. A site safety management plan identifies contractors' scope and health and safety considerations.</p> <p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers and toilets to promote safe mobilisation. The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is appropriate and secure, bathroom floors are non-slip, and walking areas are not cluttered.</p> <p>The room sizes are adequate, and the lounges and dining areas are functional and comfortable for the residents.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tag system shows this has occurred. Clinical equipment is tested and calibrated by an approved provider at least annually or when required. All maintenance records were reviewed and are clearly documented.</p> |

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|   |    | <p>The hot water temperatures are monitored monthly. Review of the records reveals temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions have been recorded.</p> <p>All external areas inspected were safe and contain appropriate seating and shade. Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.</p>   |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>Resident rooms are all single rooms with full ensuites. There is a large communal lounge and dining area downstairs and smaller dining and lounge areas upstairs. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets are well signed and identifiable and include vacant/engaged and in-use signs.</p>   |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>   | FA | <p>There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. All residents have electric beds. Nurse aides interviewed reported that rooms have sufficient space to allow cares to take place. Residents can personalise their rooms.</p>   |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet</p>  | FA | <p>There are two lounges and two dining rooms. The large downstairs dining and lounge area is used for activities, resident meetings and recreation activities. The downstairs dining room is spacious and located directly off the kitchen/servery area. The residents who dine upstairs receive a tray service. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed reported they can move around the facility and staff assist them if required. Entry to identified areas under repair have been secured with false walls to prevent entry while repairs are in progress.</p> |

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| their relaxation, activity, and dining needs.  |        |   |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>               | FA     | <p>There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the designated laundry staff. Staff attend infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's safety data charts are available for reference if needed in an emergency. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the facility.</p>   |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>  | FA     | <p>The service has an emergency and disaster manual. Fire drills are conducted six-monthly. Registered nurses and activities staff have current first aid certificates. Fire safety training has been provided. There is an electronic call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored in four 800 litre tanks. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA     | <p>All communal areas and resident bedrooms have external windows with plenty of natural sunlight. A radiator system heats the facility, with individual heating in each resident's room. On the days of audit, the general living areas and resident rooms were appropriately heated and ventilated. Residents and family interviewed stated the environment is comfortable.</p>   |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>   | PA Low | <p>The CNM is the infection control coordinator. The infection control coordinator's job description has identified delegated responsibility for infection control within the service. The infection control coordinator provides a monthly report to management and staff. The infection control programme has not been reviewed annually.</p> <p>Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks since the last audit.</p>   |

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| infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.   |    |   |
| <p>Standard 3.2:<br/>Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>  | FA | The infection control coordinator (CNM) manages infection control. The infection control coordinator has a knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, public health laboratory services and the GP. The service is a current member of bug control. |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.   |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</p>  | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required, however, the IC coordinator has completed external training.   |



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| infection control to all service providers, support staff, and consumers.  |    | Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.   |
| Standard 3.5: Surveillance<br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.   | FA | <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>There is close liaison with the general practitioner. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Monitoring and analysis of data is the responsibility of the infection control coordinator, and includes hand hygiene education and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified.</p>  |
| Standard 2.1.1: Restraint minimisation<br>Services demonstrate that the use of restraint is actively minimised.  | FA | <p>The restraint policy includes the definitions of restraint and enablers. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, six monthly care plan reviews and GP reviews. Interviews with staff confirmed their understanding of restraints and enablers, required monitoring and associated risks.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had three residents using restraint in the form of bedrails two of these also require chair brief restraints. There was one resident with bedrails as an enabler. All enabler use is voluntary. Three resident files with restraint, and one resident using the enabler were reviewed.</p> |
| Standard 2.2.1: Restraint approval and processes<br>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use | FA | The CNM is the restraint coordinator, and has a signed job description, and understands the role and her accountabilities. The policy and job description include clear responsibilities and accountabilities. All residents with a restraint in use have an assessment and consent form and regular monitoring documented.  |

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| and this process is made known to service providers and others.  |                |   |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA             | <p>Suitably qualified and skilled staff including the GP, in partnership with the resident and their family, are involved in restraint assessments.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There was a restraint assessment tool completed for the three hospital resident files reviewed for residents requiring bedrails including two residents who also use chair brief restraint for safety.</p> <p>There is a pre-printed restraint care plan and included the risks and interventions associated with restraint use.</p> <p>Ongoing consultation with the resident and relative was identified at the MDT meetings. InterRAI assessments identified risks and the need for restraint.</p>  |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>   | FA             | <p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.</p> <p>The three hospital resident's files reviewed for residents with bedrail restraint (two of these also have chair brief restraints), included specific interventions or strategies considered before use of restraint. The care plan reviewed identified observations, monitoring and relative/NOK involvement. Restraint use is reviewed through the three-monthly GP assessment, registered nurse meetings and the ethical clinical advisory group, six monthly evaluations are not always documented. A restraint register is in place, which has been completed for the three residents requiring restraint.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>  | PA<br>Moderate | <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). The restraint form and consents are reviewed six monthly at the MDT with the relatives and GP, however documentation does not always reflect this. Monitoring forms are maintained and identify when the restraint is in use and when not in use. However, not all interventions in restraint care plans have been reviewed or updated regularly as per policy. The family is included as part of the review. Evaluation timeframes are determined by risk levels.</p>  |
| <p>Standard 2.2.5: Restraint Monitoring and Quality</p>  | FA             | <p>The use of restraint is documented as discussed at registered nurses' meetings and the service ethical and clinical advisory group meetings. There have been no internal audits completed in 2018 or 2019 around</p>   |

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| Review<br>Services demonstrate the monitoring and quality review of their use of restraint. |  | restraint as per schedule (link 1.2.3.6). |
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## Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome   | Attainment Rating | Audit Evidence   | Audit Finding   | Corrective action required and timeframe for completion (days)  |
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| <p>Criterion 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p> | PA Low            | Where the resident is unable to make a decision around resuscitation, the GP has documented “not clinically indicated”. The form includes a section to verify that the family are aware of the GPs decision, however this is not always completed. | Two (both hospital) of four resuscitation orders where the GP had documented “Not clinically indicated” did not identify the decision had been discussed with family. | <p>Ensure where resuscitation orders state “Not clinically indicated”, there is also evidence of discussion with family.</p> <p>90 days</p> |
| <p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is</p>  | PA Low            | The registered nurse discusses the general consent form with the resident  | Three (hospital) of six consent   | Ensure consent forms  |

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| <p>obtained where required.</p>  |                        | <p>and/or their EPOA at the time the resident is admitted. The registered nurse then signs that they have discussed the general consents with the resident and/or EPOA. The resident and/or EPOA are required to sign the general consent form to indicate they have or have not given consent.</p>   | <p>forms had not been signed by the resident or EPOA to indicate they have or have not given consent.</p>   | <p>are signed by the resident or their enduring power of attorney.</p> <p>90 days</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> | <p>PA<br/>Moderate</p> | <p>Satisfaction surveys have been completed and analysed, and corrective actions have been documented and discussed at staff and resident meetings. Infection control and incident data is collated and analysed at the end of each month. A report is written to include this information by the CNM each month and is presented at staff meetings and the ECAC meeting. Internal audits have been completed monthly in 2019 for housekeeping, hot water temperatures, and medications, however none of the corrective actions identified have evidence of completion, or discussion held at staff meetings.</p> | <p>i) There is no evidence of any internal audits completed in 2018.</p> <p>ii) There is no planned audits schedule to include clinical, infection control and health and safety audits to be completed.</p> <p>iii) There is no evidence of completion of corrective actions.</p> <p>iv) Corrective actions have not been documented as discussed at staff meetings.</p> | <p>Ensure an internal audit schedule is developed and implemented to include audits for all aspects of service delivery. Ensure all corrective actions identified are completed, signed off and discussed at meetings.</p> <p>90 days</p> |

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| <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> | <p>PA<br/>Moderate</p> | <p>Incidents and accidents are recorded and reported to relatives in a timely manner. All reports are fully completed. Neurological observations are completed for all unwitnessed falls with a potential head injury. There is documented RN follow-up of all incidents. All incident reports are signed off by the clinical nurse manger, and discussed at meetings.</p>   | <p>i) Fifteen of fifteen incident forms reviewed do not identify opportunities to minimise risks of future incidents.</p> <p>ii) There was no incident report completed for a resident with a pressure injury.</p> | <p>i) Ensure opportunities to minimise the risk are identified on the incident reports.</p> <p>ii) Ensure incident reports are documented for all pressure injuries.</p> <p>90 days</p> |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>   | <p>PA<br/>Moderate</p> | <p>There have been education sessions held throughout 2018 and 2019 to date, however not all contractual education sessions have been held or had been planned for.</p> <p>The education sessions that have been held were relevant for staff to care for residents needs and include palliative care, and sessions by hospice, moving and handling including falls minimisation, competencies for nurse aides and registered nurses and questionnaires around professional boundaries, infection control and health and safety.</p> | <p>In the last two years, there has been no education sessions on cultural safety, continence, food safety for all staff, or restraint.</p>  | <p>Ensure all staff receive all compulsory training sessions.</p> <p>60 days</p>  |
| <p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the</p>   | <p>PA<br/>Low</p>      | <p>Progress notes are completed by the nurse aides at the end of each shift and describes implementation of required</p>   | <p>Not all designations were</p>   | <p>Ensure all progress notes written identify</p>   |

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| service provider is identifiable.  |                | interventions in the resident files sighted. All entries are legible and written in either blue or black ink. Registered nurses document in the progress notes however, entries are not always clearly identifiable.  | consistently identifiable by the registered nurses in the progress notes sighted.  | designations clearly.<br><br>90 days  |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | PA<br>Moderate | <p>Twelve electronic medication charts were reviewed. All medication signing charts reviewed aligned with the medication charts. There is a dedicated medication fridge, however temperatures are not always documented as required. Medication is securely stored, however dates of eyedrops in current use did not meet requirements.</p> | <p>(i) Medication temperatures were not consistently documented in the upstairs medication fridge.</p> <p>(ii) Four eyedrops in current use were past the documented expiry date and three eyedrops in current use did not evidence opening dates.</p> | <p>i) Ensure the temperature of the medication fridge is checked and documented.</p> <p>ii) Ensure eyedrops are dated on opening and discarded as per manufacturer's instructions.</p> <p>30 days</p> |
| <p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>  | PA<br>Moderate | <p>The controlled drug register is documented for all controlled medications; however, the time of administration is not always documented.</p>   | <p>The controlled drug register does not always include the time of administration.</p>  | <p>Ensure the controlled drug register is fully completed.</p> <p>60 days</p>   |

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| <p>Criterion 1.3.3.3</p> <p>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.</p> | <p>PA<br/>Moderate</p> | <p>Registered nurses' complete initial assessments and care plans within 24 hours of admission. Initial interRAI assessments have been completed within three weeks of admission. However, not all interRAI had been completed prior to the long-term care plan (link 1.3.5.2). Initial long-term care plans were completed, however not all within 21 days of admission. InterRAI assessments have not always been reviewed six monthly. Two of six residents (LTS-CHC and ACC residents) do not require the interRAI assessments completed. The activities coordinator completes the activities assessments and activities care plans in consultation with the resident or their family. The activities care plan is reviewed at least six monthly, however not all activities care plans had been reviewed as planned.</p> | <p>(i) One rest home resident did not have a long-term care plan documented within three weeks of admission.</p> <p>(ii) Three of three residents (one rest home, two hospital) who required interRAI six monthly reviews had not had their InterRAI assessments reviewed within required timeframes.</p> <p>(iii) Two of three (one rest home and one hospital) long-term care plans due for review have not been always been reviewed six monthly</p> <p>(iv) Three of three residents (two hospital, one rest home)</p> | <p>Ensure that all aspects of assessments, care planning and care plan evaluations are completed within the required timeframes.</p> <p>90 days</p> |
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|  |        |   | who were due for a six-monthly activity care plan review, had not had the activities care plan reviewed against the identified goals or a review completed six monthly.             |   |
| <p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>                              | PA Low | Residents care plans are evaluated. Registered nurse resident reviews are documented in progress notes, however do not evidence regular RN reviews or consistent documentation.   | The progress notes in one rest home and three hospital files reviewed did not evidence consistent review by a registered nurse including follow-up of reported pain and discomfort. | <p>Ensure progress notes evidence consistent review by registered staff.</p> <p>90 days</p> |
| <p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p> | PA Low | The registered nurses interviewed stated that the registered nurses are responsible for completing the initial assessments (including interRAI) and any other assessments required for a change in health condition. Not all resident files | One hospital resident did not have the pressure injury risk reassessed following the  | Ensure that residents are reassessed with a change in health condition.                     |

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|  |                        | sampled had evidence that the required assessments had been completed.   | development of a stage 2 pressure injury.  | 60 days   |
| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>PA<br/>Moderate</p> | <p>The registered nurse is responsible for completing all necessary assessments and then using this information to document the care plan. In the files reviewed two hospital residents had the long-term care plan documented before the interRAI assessments had been completed. The long-term care plan was not always updated following a change in care and a care plan was not always documented or updated for any acute changes in health condition. Nurses undertake a risk assessment for all residents however, interventions were not documented for all assessed care needs, and not all interventions in use had been documented in the care plan.</p> | <p>i) Three hospital residents had their care plan completed before the interRAI risk assessments had been completed.</p> <p>ii) A short-term care plan was not documented, or the long-term care plan updated to include interventions to support management of a new pressure injury.</p> <p>iii) One hospital resident (with a significant change in mobility), did not have the long-term care plan fully updated to</p> | <p>i) Ensure that the assessment process is used to provide information to inform the care plan.</p> <p>ii) -vii) Ensure that interventions are fully documented for all assessed care needs and changes in health status.</p> <p>60 days</p> |

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|  |  |  | <p>identify the resident required the assistance of two care staff.</p> <p>iv) Two residents (one hospital and one rest home) requiring wheelchair for distances did not have this documented in the care plan.</p> <p>v) One resident who was blind with significant hearing loss had no interventions documented regarding communication.</p> <p>vi) One rest home resident on anticoagulation therapy did not include the associated risks in sufficient detail to guide care staff.</p> <p>vii) One</p> |  |
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|   |                        |   | resident who required a knee brace on during certain times did not have this documented in the care plan.  |  |
| <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<br/>Moderate</p> | <p>Monitoring charts have been implemented for two hourly repositioning and response to 'as required' pain medication, however these have not been consistently completed.</p>  | <p>i) Two hospital level care residents on two hourly repositioning charts do not evidence this has occurred as planned.</p> <p>ii) The effectiveness of 'as required' analgesia has not been consistently recorded for two hospital level care residents.</p> | <p>i) Ensure monitoring charts are completed as required.</p> <p>ii) Ensure effectiveness of 'as required' analgesia is documented.</p> <p>90 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 Low</p>          | <p>The registered nurses advised that they undertake a review of the long-term care plan at least six monthly; however, this was not always evidenced on the files reviewed (link 1.3.3.3). There was evidence in the medical notes that the GP</p> | <p>Short-term care plans are not always evaluated and either resolved or added to the</p>  | <p>Ensure short-term care plans are evaluated on a regular basis and either</p>  |

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|   |             | assesses the resident with an acute change in health condition. Changes in health status are not always updated in care plans or the long-term care plan updated (link 1.3.5.2). Short-term care plans are not always evaluated and either resolved or added to the long-term care plans.   | long-term care plans  | resolved or transferred to the long-term care plan.<br><br>90 days   |
| <p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>   | PA Low      | There is an existing infection control programme in place which outlines policies and procedures, including surveillance and data collation.  | The infection control programme has not been reviewed on an annual basis.   | <p>Ensure the infection control programme is reviewed at least annually.</p> <p>60 days</p>  |
| <p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate</p> | PA Moderate | There have been no new restraints commenced since 2017, all restraints in use appear to be historical, the restraint coordinator stated the restraints were still ongoing and required. All risks identified with the use of the restraint were identified, and staff interviewed were knowledgeable around these. Monitoring forms are maintained and identify when the restraint is in use and when not in use. However, not all interventions in restraint care plans have been reviewed or updated regularly as per policy. | <p>i) Three of three restraint long-term care plans, and one of one enabler long-term care plan have not been reviewed six monthly.</p> <p>ii) One of three restraint long-term care plans contained incorrect information.</p> <p>iii) Two long-term restraint</p> | <p>(i)-(iii) Ensure all interventions in the long-term care plans for restraint are individualised and reviewed at least six monthly.</p> <p>90 days</p> |

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| <p>and maintained the safety of the consumer;<br/> (j) Whether the service's policies and procedures were followed;<br/> (k) Any suggested changes or additions required to the restraint education for service providers.</p> |  |  | <p>care plans had no evidence of review or changes in interventions since 2013 and 2017 respectively.</p> |  |
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.