

Presbyterian Support Central - Longview Home

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:

Legal entity: Presbyterian Support Central

Premises audited: Longview Home

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

Dates of audit: Start date: 1 August 2019 End date: 2 August 2019

Proposed changes to current services (if any): One room (previously used with another room to create a double room) has been returned to single room use. The room has been verified as suitable for rest home or hospital level care available. Overall bed numbers remain the same at 58.

Total beds occupied across all premises included in the audit on the first day of the audit: 51



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Longview is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 58 residents. At the time of the audit there were 51 residents in total.

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

The facility manager has been in the role for 10 months and has business management experience in aged care. The facility manager is supported by a clinical nurse manager who has been in the position for one year. The facility manager and clinical nurse manager are supported by a clinical coordinator and a team of registered nurses. Residents and family interviewed spoke positively about the service provided.

This audit identified shortfalls around quality meetings, corrective actions, staff orientation, staff training, service provision, care planning, care interventions, evaluations and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is provided and explained to residents and families. Policies are implemented to support rights such as privacy, dignity, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A manager and a clinical nurse manager are responsible for the day-to-day operations of the care facility. Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. Human resources are managed in accordance with good employment practice. An orientation programme is

established for new staff. A staff education and training programme is planned. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

<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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An admission package with information on the services provided at Longview is available prior to or on entry to the service.

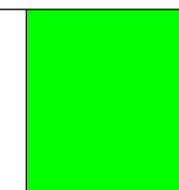
Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Electronic resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review.

The residents' activities programme provides diversional therapy activities, and these are varied and include one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of three-monthly reviews noted.

All meals are prepared on site. There is a Food Control Plan in place. The five-weekly seasonal menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for and alternative options are made available for residents.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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PSC Longview has a current building warrant of fitness. All rooms are single, personalised, and have a hand basin. There is adequate room for the safe delivery of hospital and rest home level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, craft and recreational areas, and several lounges and seating areas. Outdoor areas and the internal courtyards are safe and accessible for the residents. There is wheelchair access to all areas.

Housekeeping staff maintain a clean and tidy environment. All laundry is completed at Longview. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts.

There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Appropriate training, information and equipment for responding to emergencies are provided. A van is available for transportation of residents.

Systems are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

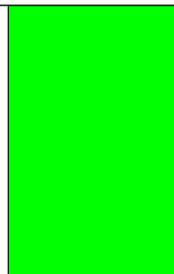


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive education and training on restraint minimisation.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (RN) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	5	0	0
Criteria	0	92	0	4	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and twelve staff interviewed (four healthcare assistants, three nurses (one clinical coordinator/registered nurse (RN), one staff RN, one enrolled nurse (EN)), two cleaners, one recreation officer, one laundry staff and one food services manager) could describe how aspects of the Code are incorporated into their job role and responsibilities. Staff receive training about the Code during their induction to the service (link 1.2.7.4), which is scheduled to be repeated three-yearly through the staff education and training programme (link 1.2.7.5).</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>	FA	<p>Residents and their families are provided with all relevant information on admission. Policies and procedures for informed consent and resuscitation are in place. General consents and specific consents where applicable are obtained on admission and updated as required. These were sighted in the eight residents' files reviewed (four hospital and four rest home files). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions.</p> <p>Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with</p>

		<p>staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's lives.</p>
<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>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) office is included in the resident information pack that is provided to new residents and their family on admission. HDC advocacy brochures are also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services. The complaints process is linked to advocacy services.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service (link 1.2.7.4 and 1.2.7.5).</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>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available. A suggestions box is held at reception.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints.</p> <p>An electronic complaints register is maintained. Three complaints have been received in 2019 (year-to-date) and were reviewed. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and a comprehensive investigation. All three complaints were documented as resolved. Missing was documented evidence that the complaints received were communicated to staff (link 1.2.3.6).</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. The manager or an RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. Eight residents (four rest home and four hospital) and six families (all hospital level) interviewed, reported that the residents' rights were being upheld by the service.</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>The residents' personal belongings are used to decorate their rooms. All rooms are single occupancy in the care facility. Privacy lights are in place for the shared toilets that are sensor operated.</p> <p>The healthcare assistants interviewed reported that they knock on doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins during their induction to the service (link 1.2.7.4 and 1.2.7.5).</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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Presbyterian Support Central (PSC) has developed a Māori health plan which was developed in partnership with kaumātua, whānau, residents and staff. It incorporates the Māori health strategy (He Korowai Oranga), Te Whare Tapa Whā, the Treaty of Waitangi principles, and the Eden principals. Connection with local iwi and marae are through residents, whānau and staff.</p> <p>The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There were no residents living at the facility who identified as Māori. Staff receive education on cultural awareness during their induction to the service and continues annually (link 1.2.7.4 and 1.2.7.5).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the care plan. All residents and families interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A code of conduct policy is discussed and signed by each new employee during their induction to the service. Professional boundaries are also defined in job descriptions. Interviews with all care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based good practice is supported through head office. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) from the local medical centre visits the facility a minimum of weekly. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Residents and families interviewed reported that they are satisfied with the services received. A guest room is reserved for guests and families of residents who are receiving palliative care. Initiatives have been undertaken to enhance the dining room experience for residents. A memorial table is in place to provide a space to acknowledge residents who have passed.</p> <p>The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Physiotherapy services are available as needed. A van is available for regular outings.</p> <p>The GP interviewed is satisfied with the care that is being provided by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a range of information regarding the scope of services provided to the resident on entry to the service. Regular contact is maintained with families including when an incident or care/health issues arises, evidenced in 10 accident/incident forms that were randomly selected for review. Interviews with families confirmed that they are kept informed.</p> <p>Interpreter and translation services are available if needed. There is one resident who is unable to converse in English. The family assisted in providing appropriate signage to enhance</p>

		<p>communication with this resident.</p> <p>The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>PSC Longview Home provides rest home and hospital level care for up to 58 residents. As part of this audit, one additional room has been verified as suitable for rest home or hospital level of care (this room was previously part of a double room. In the past two single rooms had been converted to one large/double room. Now the two rooms have been converted back to two single rooms). Overall beds numbers have not changed. On the day of the audit there were 51 residents (29 at rest home level and 22 at hospital level). All residents' rooms are certified for dual purpose and all the residents were on the age-related care contract (ARCC).</p> <p>The manager has worked in the public, private and not-for profit sectors. She has been in her role at Longview since September 2018. Previous to this role she was a retirement village manager at a facility with rest home, hospital and dementia levels of care from 2016-2017. She is supported by a clinical nurse manager who has been an RN for 21 years; nine years in New Zealand. She has six years of experience in the aged care sector and has been in her role for one year. A clinical coordinator/RN supports the clinical nurse manager and has been in this role for three months.</p> <p>PSC Longview Home is guided by a philosophy, vision and values. They have adopted the Eden philosophy of care, which is considered 'elder-directed' care. A 2019-2020 business plan lists specific goals that are reviewed quarterly.</p> <p>The manager and clinical nurse manager have attended a minimum of eight hours each of professional development activities related to their managerial roles.</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>	FA	<p>The clinical nurse manager is responsible for operations during any absence of the manager. The clinical coordinator is responsible for clinical operations in the absence of the clinical nurse manager.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management programme is established through the PSC head office. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff. The manager and clinical nurse manager are held accountable for their implementation.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure areas. Data is collated and benchmarked against other PSC facilities to identify trends. Results are posted in the staff room. A resident/family satisfaction survey is completed on an annual basis. Results were slightly lower in 2019 than the previous year. An annual internal audit schedule is being implemented with audits completed as per the schedule. Missing was adequate evidence in the meeting minutes to confirm that satisfaction survey results, internal audit results and complaints received were being communicated to staff in the general staff meetings.</p> <p>Corrective actions were not routinely developed where opportunities for improvements were identified (eg, facility health check, resident satisfaction survey). Also missing was evidence that corrective actions were discussed in the general staff meetings.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised.</p> <p>The health and safety programme meets current legislative requirements. It is overseen by a health and safety officer and is supported by a health and safety team. A contractor induction programme is in place. Hazard identification forms and an up-to-date hazard register are being implemented.</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>FA</p>	<p>The service collects data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system. Immediate actions taken are documented on accident/incident forms. The ten clinical incidents/accidents reviewed (held electronically on Leecare) were reviewed and investigated by an RN. If risks are identified, these are processed as hazards and are reported to the health and safety officer for evaluation at health and safety meetings.</p> <p>Discussions with the manager and clinical nurse manager confirmed their awareness of statutory requirements in relation to essential notification. This has been required in relation to notification for two pressure injuries.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Job descriptions are in place for all positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Eight staff files were reviewed (four healthcare assistants, one clinical nurse manager, one clinical coordinator/RN, two staff RNs). Evidence of signed employment contracts, and job descriptions were sighted.</p> <p>Annual performance appraisals for staff were behind schedule. Newly appointed staff complete an orientation that is specific to their job duties, but this was not able to be evidenced for the RNs. Interviews with the healthcare assistants confirmed that the orientation programme included a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is being implemented for 2019 for all staff but did not take place for healthcare assistants in 2018. Attendance is recorded. A system for determining staff competency is implemented. Only two staff (clinical nurse manager and the recreation officer) hold current CPR/first aid certificates.</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. The manager and clinical nurse manager are employed Monday – Friday. The clinical coordinator works Sunday through to Thursday.</p> <p>The facility is rostered into two teams of care staff. Team one is responsible for two wings (four rest home and nineteen hospital level residents). Two RNs (or one RN and one EN) are rostered on the AM and PM shifts (one long shift and one short shift). Two long shift and two short shift healthcare assistants (HCAs) are rostered on the AM shift. One long shift and three short shift HCAs are rostered on the PM shift.</p> <p>Team two is responsible for four wings (25 rest home and three hospital level residents). One long and two short shift HCAs cover the AM shift and the PM shifts.</p> <p>The night shift is staffed with one RN and two HCAs. There is separate staffing for laundry and cleaning duties, seven days a week. Activities staff are rostered seven days a week.</p> <p>Interviews with residents and families confirmed that they felt there was sufficient staffing although they reported that there are times that the staff are unable to answer the call bell in a timely manner. This is currently being investigated by the manager. The roster is able to be changed in response to resident acuity.</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>	<p>FA</p>	<p>The residents' files are appropriate to the service type. The facility has recently transitioned to electronic clinical records using Lee care. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. All computer access is individually password protected. Hard copy archived records are secure in separate locked areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant HCA or nurse, including designation.</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>	<p>FA</p>	<p>Prior to entry to PSC Longview, potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. Eight admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. The clinical coordinator and a registered nurse described the entry and admission process.</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>	<p>FA</p>	<p>A transfer document, summary care plan and medication profile are electronically generated when residents are transferring to hospital. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The rest home and hospital areas have separate medication rooms. The medication trolleys are kept in a locked medication room accessed from a locked nurses' station. Controlled drugs are stored in a locked safe in the medication room.</p> <p>Registered nurses, enrolled nurses or medication competent carers administer medications from robotic rolls on medication rounds. These staff have been assessed for competency on an annual</p>

		<p>basis and attend annual medication education. RNs attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There was one resident self-medicating on the day of audit. Three-monthly competency assessments and safe storage are in place. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening.</p> <p>Sixteen medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The 16 medication charts included three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication round. Controlled medication administration was not always fully documented.</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>All meals are prepared and cooked on site at PSC Longview. The Food Control Plan expires on 23 January 2020. The food services team leader (a qualified cook), is responsible for the operations of food services. The kitchen team includes the food services team leader, a second cook and kitchenhands. There is a five weekly rotating summer and winter menu that is reviewed by the company dietitian. Food services policies and procedures manual are in place.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook has access to the electronic patient management system and maintains a list of residents' dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. A recent food survey identified most residents were very happy with the service.</p> <p>Input from residents and food surveys, provide resident feedback on the meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>Daily hot food temperatures are taken and recorded for each meal. All meals are dished direct from a bain marie in the main kitchen and served to residents in the dining room. A self-serve station is available for lunch and tea meals for those who wish to serve themselves. All other meals are dished direct from a bain marie in the main kitchen and either served to residents in the dining room or delivered on trays to residents in their rooms. Holding temperatures are taken from the self-serve bain marie. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date-labelled</p>

		<p>and stored correctly. The well-appointed kitchen has a separate dishwashing area, preparation, cooking, baking and storage areas.</p> <p>Chemicals are stored safely. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</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 appropriate.</p>	FA	<p>If entry is declined, the management staff at PSC Longview communicate directly with the referring agencies and potential resident or family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>There was evidence in files sampled that the RN completes an initial admission assessment within 24 hours which includes relevant risk assessment tools for all residents. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others.</p> <p>All of the eight files reviewed, included interRAI assessments (link 1.3.3.3). One long-term resident under the ARC had interRAI assessments completed within the required timeframe. Additional assessments for management of wound care were appropriately completed according to need.</p> <p>The long-term care plans did not always fully reflect the outcome of the assessments (link 1.3.5.2).</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 RN develops the long-term support plan from information gathered over the first three weeks of admission. Care plans are individually developed with the resident, and family involvement is included where appropriate. The RN is responsible for all aspects of care planning. Not all care plans included goals and specific interventions for all identified care needs. Assessments and care plan's included input from allied health including the GPs, nurse specialist, and podiatry. Physiotherapy is available if needed.</p> <p>Care plans are updated with changes as they occur. Short-term care plans are integrated with</p>

		<p>wound management plans and provide direction for care staff.</p> <p>Medical GP notes and allied health professional progress notes are evident in the residents integrated files sampled.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>A health status summary held in the resident's electronic records documents significant events, investigations, GP visits and outcomes. The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to residents' health status. Resident files sampled recorded communication with family.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were 21 wounds and three facility acquired pressure injuries (one deep tissue, one stage three and one stage one) being treated on the day of the audit. Two rest home residents had three wounds each and one hospital resident had five wounds, one had three wounds and two had two wounds each. A sample of eight wounds were fully reviewed. Wound assessments had been completed for all wounds, however not all wounds had individualised plans. Wound management plans were not always followed.</p> <p>There was evidence of GP involvement and wound nurse specialist involvement for two pressure injuries (stage three and deep tissue) for which a section 31 was completed. There was evidence of GP involvement and/or wound specialist nurse input. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Caregivers are alerted to the requirement to complete electronic daily monitoring charts and are advised of specific resident needs at handovers. The active short-term care plans and long-term care plans are in the electronic software system used for resident care. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are not always completed as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>The service employs two recreation officers. The full time (qualified) and part time recreation officers provide a seven day a week activities programme for rest home and hospital level care residents. A chaplain also provides spiritual and pastoral care to residents. There are 15 volunteers who work with recreation staff to provide entertainment and events to residents,</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>games, craft, outings and events. There are two canine friends who have been visiting the residents regularly three times a week.</p> <p>The activities programme is displayed on a weekly A3 calendar with large font. It includes (but is not limited to) chair exercises, moving to music, old fashioned morning tea, musical instruments and sing a longs, school visits fortnightly and church services. There are regular outings into the community with a volunteer van driver and a recreation officer with a first aid certificate.</p> <p>There is a range of activities to meet the recreational preferences and individual abilities of the residents. One-on-one time is spent with residents who choose not to participate in the group programme. The activities coordinator completes a resident social profile and activities assessment on admission. Each resident has an individualised activity plan which is reviewed six monthly. The residents have the opportunity to provide feedback on the programme through three monthly resident meetings and survey results. The residents and relatives interviewed commented positively on activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Six of the eight residents' files sampled had been in the facility for longer than six months. There was evidence in these files of evaluations of the support plan (link 1.3.3.3 and 1.3.5.2). There was at least a three-monthly review by the GP. Care plan reviews are signed by the RN in files sampled, however progress towards goals is not always documented.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <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>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. A transfer document, summary care plan and medication profile are electronically generated when residents are transferring to hospital. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and their families are kept informed of the referrals made by the service. The RNs interviewed described the referral process to other medical and non-medical services.</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</p>	<p>FA</p>	<p>The service has policies and procedures for the disposal of waste and hazardous material. There is an incident system for investigating, recording and reporting all incidents. The chemicals supplies are kept in locked cupboards in service areas. A chemical spills kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps.</p>

<p>or hazardous substances, generated during service delivery.</p>		<p>Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current building warrant of fitness which expires 21 March 2020.</p> <p>The maintenance person is employed eight hours per week and carries out minor repairs and maintenance, reactive and preventative maintenance. There is an annual maintenance plan, with monthly checks, which include hot water temperatures, testing the generators, maintenance of resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment is calibrated annually. Essential contractors are available after hours.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.</p> <p>The facility has a van available for transportation of residents, with a current warrant of fitness and registration. Those staff transporting residents hold a current first aid certificate.</p> <p>The caregivers and RNs stated they have enough equipment to safely deliver the cares as outlined in the resident care plans. There are adequate storage areas for hoist, wheelchairs, products and other equipment.</p> <p>As part of this audit, one additional room has been verified as suitable for rest home or hospital level of care (this room was previously part of a double room. In the past two single rooms had been converted to one large/double room. Now the two rooms have been converted back to two single rooms).</p> <p>There is a designated external smoking area.</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>	<p>FA</p>	<p>All resident rooms are single. There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Call bells are available in all toilet/shower areas. All bedrooms have a hand basin and share an ensuite toilet. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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>	<p>FA</p>	<p>All resident rooms in the facility are of an adequate size for rest home or hospital level of care. The bedrooms allow for the resident to move about the room independently or with the use of mobility aids. The hospital bedrooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirmed their bedrooms are sufficiently spacious and they can personalise them as desired.</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 their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a spacious lounge and dining area to meet the needs of the residents. There is also a chapel (used for a number of activities) and a large craft room to allow for activities, resident relaxation and to provide privacy for residents and visitors. Two wings have smaller lounge/dining areas and there is a conservatory. The facility design allows for freedom of movement for all residents including those with mobility aids. Staff assist residents to access communal living areas as required and this was observed on the day of the audit.</p>
<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>	<p>FA</p>	<p>All personal clothing and laundry are laundered on site. There is a laundry person seven days a week from 8.30 am to 3.30 pm. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped, and the machinery is regularly serviced. Personal protective clothing is available including gloves, aprons and face masks. Adequate linen supplies were sighted. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services.</p> <p>Two cleaners are rostered on for four and a half hours each day Monday to Sunday. The cleaners' cupboard containing chemicals is locked. Cleaners' trolleys are well equipped and kept in locked areas when not in use. All chemicals have manufacturer labels. Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. There is a daily and monthly room clean schedule. The cleaning staff have completed chemical safety training.</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>	<p>FA</p>	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and annual education and training programme include fire and security training (link 1.2.7.4 and 1.2.7.5). Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required</p>

		<p>timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies readily available on each floor of the facility in the event of a civil defence emergency including food, water, and blankets. A gas barbeque and a generator are available in the event of a power outage.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Only the clinical nurse manager and recreation officer hold current CPR/first aid certificates (link 1.2.7.5).</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 resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is a RN who has been in the role for ten months and has a current job description. On the day of audit, the infection control coordinator was on leave and the clinical coordinator was interviewed. The infection control coordinator is supported by the clinical manager. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators peer support day held with the PSC clinical director and nurse consultant last in September 2018.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is enough personal protective equipment available. Residents and staff are offered the influenza vaccine. There have been no outbreaks.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement</p>	FA	<p>The infection control coordinator has attended the annual infection control coordinators peer support group within the organisation that includes in-service, review of policies/procedures, infection control programme and sharing of information/experiences. The infection control coordinator has access to expertise within the organisation, DHB infection control nurse specialist,</p>

the infection control programme and meet the needs of the organisation.		public health, GPs and laboratory service.
Standard 3.3: Policies and procedures 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.	FA	The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control education is part of the annual education schedule. All staff complete infection control education on orientation. Registered nurses and enrolled nurses complete self-learning packages. Infection control is discussed at all facility meetings and at handovers. Hand hygiene audits are completed annually. There is an infection control board in the staffroom with notices, meeting minutes, staff newsletters and graphs to keep staff informed on infection control matters. Resident education is expected to occur as part of daily activities.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Longview. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of reported infections (on Leecare) is analysed with trends and corrective actions identified. Surveillance data is discussed at senior team meetings and clinical meetings.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures to manage restraints and enablers. During the audit there was one (hospital level) resident using a t-belt as a restraint and one (hospital level) resident who consented to using bedrails as an enabler. The file of the resident using an enabler was reviewed. An enabler assessment was completed (11 January 2018) with evidence sighted of

		<p>three-monthly reviews. The resident verbally requested the cot sides to assist him in feeling safe and mobilising in bed. The use of this enabler was linked to his care plan with risks documented.</p> <p>Staff receive mandatory training around restraint minimisation. This is taking place in 2019 with evidence sighted of staff attending.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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 and this process is made known to service providers and others.</p>	FA	<p>The clinical nurse manager is the designated resident coordinator. She is knowledgeable regarding this role and is responsible for completing restraint assessments. She also monitors staff compliance to restraint processes.</p>
<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>Only registered nursing staff can assess the need for restraint if the clinical nurse manager (restraint coordinator) is unavailable. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard.</p> <p>One (hospital level) resident's electronic file where restraint was being used (t-belt) was reviewed. This file included a restraint assessment and consent form that was approved by the resident's family. Restraint use was linked to the resident's care plan and was reviewed three-monthly. Their care plan provided factual information in assessing the risks of safety and the need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off. Monitoring for the resident using a t-belt is scheduled for hourly with two-hourly mobilising but the monitoring form reflects less frequent checks (link 1.3.6.1).</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed three-monthly by the restraint coordinator. Reviews cover aspects listed under the criterion (a – (k). Restraint use is an agenda item in the monthly RN meetings.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the PSC head office.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement data is being collected, analysed and evaluated. Data is benchmarked against other PSC facilities and is posted in the staff room. An internal audit programme is being implemented. Missing is evidence of internal audit results and complaints being communicated to staff.	There are gaps in meeting minutes around the reporting of internal audit results (eg, resident satisfaction survey results, facility health check, internal audit results, complaints received (if any) and corrective actions being implemented).	Ensure staff are kept informed of internal quality results and corrective actions. 90 days
Criterion 1.2.3.8 A corrective action	PA Low	A corrective action process is established but is not fully implemented at this facility.	i) Evidence to support the implementation and the evaluation of corrective action plans were missing in	Ensure corrective

<p>plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>			<p>two (2019) internal audits reviewed (the dining experience, activities).</p> <p>ii) Corrective action plans were not established where results from the facility health check indicated that improvements were required.</p> <p>iii) Corrective actions were not developed where indicated to address resident satisfaction survey results.</p>	<p>action plans are implemented and evaluated.</p> <p>90 days</p>
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>All staff undergo a general orientation. The care staff are required to completed additional orientation documentation and have six months to complete this programme. The RN staff files reviewed indicated that they have not submitted their documentation to evidence that it has been completed.</p>	<p>Care staff have six months to complete their orientation programme. Four RN staff files reviewed of staff who have been employed for longer than six months but within the past two years indicated that the RNs (clinical nurse manager, clinical coordinator, two staff RNs) have not submitted their completed orientation paperwork.</p>	<p>Ensure all staff can demonstrate evidence that they have completed the required orientation programme for their respective roles.</p> <p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>All mandatory training is completed on a three-yearly cycle. Evidence was sighted of the RNs completing required education and training, but there are gaps in the attendance of mandatory training for healthcare assistants. Only two staff (clinical nurse manager and the recreation officer) hold current CPR/first aid certificates.</p>	<p>(i). Mandatory training for healthcare assistants is missing for 2018 (covering the aging process, code of rights, communication, complaints, dementia, cultural training/Treaty of Waitangi, Eden principal #4). Note: this was during a period of time where healthcare assistants were requested to attend education at other facilities and leadership within the facility was not consistent).</p> <p>(ii). Only two staff (clinical nurse manager and the recreation officer) hold current CPR/first aid</p>	<p>(i). Ensure all healthcare assistants complete all three cycles of the mandatory training programme.</p> <p>(ii). Ensure</p>

			certificates.	there is a staff member across 24/7 with a current first aid certificate. 90 days
Criterion 1.3.12.6 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.	PA Moderate	The controlled drug register is completed for all controlled drug administration. The controlled drug registers in the hospital unit consistently record all details including the time of administration, however this was not always documented in the rest home.	(i) Six entries in the controlled drug register do not evidence the time of administration. (ii) Two entries in the controlled drug register do not evidence a second signature.	(i) and (ii) Ensure the controlled drug register is fully documented as required. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Registered nurses' complete initial assessments and care plans within 24 hours of admission. Initial interRAI assessments were completed within 21 days for three residents. Long-term care plans were completed within 21 days of admission for four residents. InterRAI assessments have been reviewed six monthly for one of six residents requiring review. Two residents do not require the interRAI assessment completed. Care plan evaluations have been completed six monthly for two of six residents. Two residents do not require the interRAI assessment completed. Activities care	i) Five of eight resident files (two rest home and three hospital) reviewed did not have an initial interRAI completed within 21 days. ii) Four of eight files (one rest home and three hospital) did not have an initial care plan completed within 21 days. iii) Five of six residents (two rest home and three hospital) files reviewed did not have interRAI assessments completed six monthly. iv) Four of six residents (one rest home and three hospital) did not have care plan evaluations completed six monthly. v) Activities care plan evaluations have not been	Ensure all interRAI assessments, care plans and care plan reviews are completed within required timeframes. 60 days

		plans have been completed in required timeframes for six of eight resident files reviewed.	completed six monthly for two residents (one rest home and one hospital).	
<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</p> <p>Moderate</p>	<p>Long-term care plans were documented by the registered nurse. All residents had a long-term care plan in place. HCAs were knowledgeable about the individual resident care needs. The care plans documented the resident health conditions but did not always document the goals of care. 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) Two hospital and one rest home resident did not have goals of care documented. (ii) Three residents (two rest home and one hospital) using hip protectors on a daily basis did not have these documented in the care plan. (iii) Interventions had not been fully documented in the long-term care plan for; a) one rest home resident identified as a frequent faller, b) one hospital resident, with pain and weight loss, c) one rest home resident on continuous oxygen, requiring pain management, d) one rest home resident with pain management requirements, e) one hospital level care resident with type two diabetes and unstable blood sugars, f) one hospital resident with interRAI triggers of mood and behaviour and undernutrition with recent weight loss, and g) one hospital resident with interRAI triggers of bowel management and mood</p>	<p>(i) Ensure all residents care plans include goals of care. (ii) Ensure all interventions in use are documented in the care plan. (iii (a to g) Ensure that care plans have interventions and care documented for all assessed resident needs.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the</p>	<p>PA</p> <p>Moderate</p>	<p>All identified wounds had an assessment, wound plan care plan and evaluations documented, but not all reflected the wound care occurred as scheduled or was on an individual plan. Staff were evidenced to be caring and attentive to residents with resident and family member agreeing that caregivers were kind and caring.</p>	<p>(i) Eight wound care plans did not evidence that dressings occurred at the scheduled frequencies.</p> <p>(ii) One resident had three chronic wounds on the same assessment and dressing plan.</p> <p>(iii) Effectiveness of 'as required' analgesia was not documented for three residents.</p>	<p>(i) Ensure wounds are dressed according to the wound management plan</p>

<p>consumers' assessed needs, and desired outcomes.</p>		<p>Monitoring of residents to ensure their safe and effective care was not always fully implemented.</p>	<p>(iv) Monitoring and/or repositioning charts were not completed as scheduled for: two hospital residents requiring repositioning, two hospital residents on food and fluid charts, one hospital resident on a fluid output chart and one hospital resident on restraint monitoring.</p>	<p>timeframes.</p> <p>(ii) Ensure all wounds are documented on individual management plans.</p> <p>(iii) Ensure the effectiveness of 'as required' analgesia is documented.</p> <p>(iv) Ensure all monitoring and repositioning charts are completed as scheduled.</p> <p>60 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired</p>	<p>PA Low</p>	<p>A registered nurse signs the care plan as reviewed and participates in multidisciplinary meetings as evidenced for three residents.</p>	<p>Three resident care plan reviews did not document progress towards meeting goals.</p>	<p>Ensure evaluations include progress towards goals.</p> <p>90 days</p>

outcome.				
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.