# Otago Care Limited - Woodhaugh Resthome and Hospital

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Otago Care Limited

**Premises audited:** Woodhaugh Resthome and Hospital

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

**Dates of audit:** Start date: 14 August 2018 End date: 15 August 2018

**Proposed changes to current services (if any):** Room 53 was verified as suitable to be used as a double room for a couple.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 43

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Woodhaugh rest home and hospital is privately owned. Woodhaugh provides rest home and hospital (geriatric and medical) level of care for up to 70 residents. On the day of the audit there were 43 residents.

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

The director/facility manager is on site forty hours a week and has attended training related to the management of an aged care facility. He is supported by an interim clinical manager, registered nurses and staff. Staff receive education and have policies and procedures in place to guide them in the safe delivery of care.

There are ongoing environmental improvements and renovations occurring.

The service has addressed six of the ten shortfalls from their previous certification audit around, orientation, training, staffing, privacy of information, contract timeframes and medication management.

Further improvement continues to be required around progress notes, care planning interventions, wound management, and completion of renovations.

This surveillance audit identified improvements required internal audits, and compliance around toilet and shower facilities.

## 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. |

Information about services provided is readily available to residents and families. The management team operate an open-door policy. There are regular resident meetings. Complaints processes are implemented, and complaints and concerns are managed appropriately.

## Organisational management

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

The owner/facility manager role has previously worked in public service roles in Australia and New Zealand. He is supported by an experienced interim clinical manager who is filling the role until the newly employed clinical manager commences employment. They are supported by registered nurses and care staff.

The business plan has goals documented. Policies and procedures are appropriate to provide support and care to residents’ rest home and hospital level needs. There is a documented quality and risk management programme. Facility meeting minutes include discussion around quality data.

Staff receive ongoing training and there is a training plan developed and commenced for 2019. Human resources policies are in place, including a documented rationale for determining staffing levels and skill mixes.

## Continuum of service delivery

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

Registered nurses assess, plan, review and evaluate residents' needs, outcomes and goals with the resident and/or family/whānau input and are responsible for each stage of service provision. Care plans demonstrate service integration and were evaluated at least six monthly. Resident files were electronic and included medical notes by the general practitioner and visiting allied health professionals.

The activity team provide and implement a varied and integrated activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and resident preferences.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines. All staff responsible for medication administration complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three monthly by the general practitioner.

Meals are prepared on site. The menu is developed under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The building has a current warrant of fitness and emergency evacuation plan.

## Restraint minimisation and safe practice

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

The service actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There were no residents using enablers and no residents using restraint.

## Infection prevention and control

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

An infection control policy includes surveillance activities. The surveillance programme is appropriate to the size and complexity of the facility. Infection information is collected and collated monthly by the interim clinical manager, who is the interim infection control coordinator.

## 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 | 13 | 0 | 2 | 3 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 3 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The owner/manager and the interim clinical manager operate an ‘open door’ policy. The complaint register is maintained and is available in the electronic system. There have been four complaints since the previous audit. All letters of acknowledgement and follow-up letters have been sent within required timeframes, and the complainant signs a slip if they are happy the matter has been resolved (or not). All four complaints since the previous audit have been resolved. Residents and relatives confirmed they are aware of the complaints process. The four healthcare assistants interviewed were able to describe the process around reporting complaints, and confirmed complaints are discussed at meetings.  The previous HDC complaint remains open. Woodhaugh have supplied evidence required and will submit further evidence at twelve months as requested by the commissioner. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Seven residents interviewed felt comfortable in approaching the facility manager/owner, clinical manager for any concerns. Residents have the opportunity to feedback on service delivery through the monthly resident meetings. Ten accident/incident forms reviewed evidenced that relatives are informed of any incidents/accidents. The two relatives (rest home) interviewed stated they have been notified promptly of any changes to resident’s health status. An interpreter service is available if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Woodhaugh provides residential services for up to 70 residents requiring rest home or hospital (geriatric or medical) level care. On the day of audit there were 43 residents – 22 at rest home level care including one on respite care and 21 at hospital level of care including two LTS-CHC and one YPD.  There are 31 dual-purpose rooms and 39 rest home only. On the day of the audit, the upstairs Gables wing was not in use. Room 53 was verified as a suitable to be used as double room during the audit, which was currently occupied by a married couple.  The owner is the facility manager (non-clinical) and has been in the role since March 2018. The manager provides organisational oversight and management of the facility. The previous clinical manager had recently resigned, another has been appointed, but not yet commenced employment. There is an interim clinical manager supporting the manager in the meantime, who has previous clinical management experience and a background in age care. The MOH have been fully informed of the changes. A handover period has been arranged between the outgoing and incoming clinical managers.  The goals and direction of the service are documented in the business plan.  The manager has completed eight hours education related to the running of an aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | An electronic document control system is in place. Woodhaugh contract a quality consultant who acts as a clinical advisor including policy review. She is also available for clinical support, developing new policies or changes to policy. These are communicated to staff, which is evidenced in meeting minutes reviewed. There is a quality improvement plan in place for 2018 and 2019, which is due for review in October 2019. Goals and progress towards meeting these are discussed at staff meetings. There is a current risk management plan in place.  The facility manager (FM) facilitates the quality programme and ensures the internal audit schedules are implemented, however due to the gap between the outgoing clinical manager (CM) leaving and the newly appointed CM starting the internal audits have not been completed according to the schedule. The FM is currently also reviewing the environmental internal audit tool, so it is more meaningful to Woodhaugh. Corrective action plans have been developed, implemented and signed off when service shortfalls have been identified. Quality improvement processes are in place to capture and manage non-compliances. All quality improvement data is discussed at monthly safety/quality/risk/staff meetings.  Since the previous audit, Woodhaugh have implemented quality initiatives including; reviewing and changing GP services to provide a better after-hours service for the residents. Changes have been made with the suppliers of continence and chemical products, which includes more education available to staff. The contracted dietitian and physiotherapists are now involved with the MDT meetings six monthly. A new version of the electronic system is being developed to improve documentation and to be more user friendly (eg, wound charts). They have engaged with the Hospice cultural liaison to improve this area for residents and staff. The facility has engaged with a companionship project with the community, where volunteers visit residents who do not have family or regular visitors.  The health and safety officer (FM) is covering the role until the new CM is settled in the role. The FM has completed external health and safety training. The hazard register is stored on-line and includes required actions and regular reviews. The on-line register is available for all staff to view and is posted on staff noticeboards to increase staff awareness.  There are resident and relative surveys conducted and analysed with corrective action plans developed when required. The 2018 resident survey demonstrated satisfaction in most areas. Individual concerns were addressed. A corrective action plan identified that improvements are being addressed in areas where results were sub-optimal.  The 2019 relative satisfaction survey showed 73% of relatives were very satisfied and 27% of relatives were satisfied overall. The resident satisfaction had a 57% return rate and 100% of respondents felt their expectations were being met.  Areas of high satisfaction from both residents and relatives were staff being courteous, care planning consultation, call bells being answered promptly, activities, housekeeping, and laundry services.  There is a food survey/audit that has been completed on a regular basis to improve satisfaction with residents and new initiatives include a pizza night and a weekly high tea, which relatives are invited to share.  Falls prevention strategies include an investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Other strategies include sensor mats, and regular checks on residents at risk of falling. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents on an electronic database. Incident/accident is entered by staff that have either witnessed an adverse event or were the first to respond. The RN on duty conducts a clinical review of the resident following an incident. Ten incidents sampled for July and August 2019 demonstrated appropriate documentation and clinical follow-up including neurological observations and identified opportunities to minimise future risks. Accidents and incidents are analysed monthly, with results discussed at quality/clinical/staff meetings.  The facility manager is aware of situations that require statutory reporting. There was a suspected outbreak, where all residents and staff involved were treated, all notifications were completed in a timely manner. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Five staff files sampled (two registered nurses, and three healthcare assistants) showed appropriate employment practices and documentation. Current annual practicing certificates are kept on file.  New staff are interviewed by the facility manager and the clinical manager (sighted on the day of the audit).  New staff are buddied with experienced staff for an orientation period of two to three days or longer if required. Staff interviewed reported they were buddied during the orientation process, and to the shift pattern they will be working, (sighted with new staff during the audit). They continued to feel supported within the team after the orientation period. There is clinical support for less experienced registered nurses from the clinical manager and the Hospice CNS as required.  The orientation checklist is completed by the new staff and their preceptor and reviewed by the clinical manager. The orientation package has been reviewed and provides information and skills around working with residents with aged care needs, this evidenced as completed in four of the five files reviewed (one staff member had been on staff for 10 years). The previous finding around orientation has been addressed.  Staff files sampled contained a current annual performance appraisal for those staff who had been employed for a year of more. During the appraisal, there is a review of staff competencies and these are completed prior to the appraisal interview. These were complete and up to date for three of five staff (one new staff, and one due in August).  There is an annual training plan in place and implemented that covers all compulsory training and according to resident’s needs (ie, BIPAP and diabetes). A range of outside speakers attend the facility. Education attendance records evidence more than 50% attendance. Woodhaugh have engaged with an external provider working with young people volunteer placements and on completion of the course are level 2 Careerforce trained in health and wellbeing. Woodhaugh have recently hired staff from this programme.  Woodhaugh encourage staff to commence Careerforce educations within the first year of employment and have contracted an external assessor for the facility. Currently there are two HCAs with a level 3 qualification and one with a level 4 qualification. There are a further two HCAs completing level 2, four completing level 3 and two completing level 4. The previous finding has been addressed.  The service reports a high staff turnover of registered nurses and is continuing to implement strategies to manage this and were actively employing enrolled nurses to provide more clinical oversight. As previously, management advised that much of that has been to do with immigration and RNs moving on. The facility has recently employed registered and enrolled nurses, (enrolled nurses have not yet commenced employment).  There are currently five RNs and one on orientation employed at Woodhaugh and two full-time staff are interRAI trained with a further RN completing training. This was confirmed by rosters, and registered nurse interview. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a staffing policy that includes staff skill mix. The service reports a high staff turnover of registered nurses.  The electronic rostering system tracks when staff are not available (eg, annual leave and sick). The roster is colour coded to identify roles of all staff on the roster. The two-week roster printed from the system identifies when staff were sick, and how the role was covered. Staff on orientation were highlighted (for auditor identification). The two-week roster provided identifies two days on each weekend where staff called in sick, not all of the roles were able to be covered. The staff on duty offered (and worked) extra hours to ensure continuity of care for the residents. The staff that worked extra shifts had appropriate rest days. There are currently two casual HCAs staff that the service can call on to cover leave. The staff interviewed reported the service tries their best to cover sick leave, registered nurses are available to help, and sick leave is covered most of the time. Staff and residents interviewed felt call bells are answered in a timely manner, and this was reflected in the residents’ 2019 survey. During the audit, call bells were noted to be answered promptly. The previous finding has been addressed.  The facility manager monitors the extra hours staff works and ensures staff have rest days. The facility manager (non-clinical) and the clinical manager are always on call. If for any reason the clinical manager cannot be contacted the quality control advisor is available 24/7. The facility manager creates the rosters with input from the clinical manager. The quality control advisor is an RN and has been involved with the service for many years. She is not based at Woodhaugh but can be contacted by phone at any time.  There is a registered nurse rostered on each shift. The clinical manager was working full time (9 am to 5.30 pm) on the week of the audit and had limited availability prior but was available via phone and covered call. The facility manager works from 9 am-5.30 pm Monday to Friday.  At the time of the audit, there were 43 residents (22 rest home and 21 hospital level residents)  Morning shift has; 1 x HCA 7 am to 3.15 pm, 2 x HCA 7 am to 3 pm, and 2 x 7 am to 1 pm.  Afternoon shift has; 1 x HCA 3 pm to 11.15 pm, 1 x 3 pm to 11 pm, and 2 x 3 pm to 10 pm.  Night shift has 2 x HCAs 1 x 11 pm to 7 am and 1 x 11 pm to 7.15 am.  A cook works from 7 am to 3 pm, kitchenhand works from 12 md to 7 pm, and a cleaner from 9.30 am to 3 pm are rostered on duty each day. Laundry is completed externally. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Since the previous audit the facility manager has adjusted the accessibility of information available to staff. All staff have access to clinical information, policies and procedures, education sessions planned and the roster. Progress notes and other information cannot be deleted, overwritten, or changed at any time. If there is a note written in error, staff contact the facility manager who can unlock the system, and delete the error, this creates a log, which identifies the date, time and identifies who has made the amendment. This information cannot be deleted as demonstrated on the day of the audit. The previous finding has been addressed. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Twelve electronic medication charts were reviewed including the electronic chart for the respite resident. There are policies available for safe medicine management that meet legislative requirements. The service uses an electronic medication management system. The medication charts reviewed, identified that the GP had seen and reviewed the resident at least three-monthly. The previous shortfall has been addressed.  All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses interviewed could describe their role regarding medication administration. All medications are checked on delivery against the medication chart as documented on the electronic system. Discrepancies are fed back to the pharmacy.  Standing orders are not used. There were no residents self-medicating on the day of audit.  The medication room was clean and secure, there were no expired medications in stock. The previous shortfall has been addressed. The medication trolley was clean, and all eye drops dated. The medication fridge temperature is recorded regularly and is within the acceptable ranges.  Staff observed during the medication rounds demonstrated safe practice. The previous finding has been addressed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on site by the cook/chef and kitchenhand, there is a second cook (in training, not yet qualified) who works when the main cook has days off. The cook has designed the menu and prepared and cooked meat ready to slice to be easier for the second cook.  There is a four-weekly seasonal menu in place, which was reviewed by a dietitian in July 2018. The kitchen is informed of resident dietary needs and changes by the registered nurses. Likes and dislikes are accommodated, the cook was knowledgeable of residents with weight loss and likes and dislikes of residents. Additional or modified foods such as soft foods, pureed and vegetarian meals are provided. If required, changes are made to the menu, this was documented (eg, meatloaf swapped for meatballs). Food is taken from the kitchen in bain marie containers and served in the dining room by care staff. The food service was included in the recent resident survey and results had evidenced improvement on previous audits. All but one resident was complimentary of the food and all enjoyed the weekly high tea; relatives interviewed were happy with the meals service.  The main kitchen is adjacent to the dining room where all meals are prepared. Meals are plated and served to residents in the dining room. A food control plan has been applied for. Fridge and freezer temperatures are monitored and recorded daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained.  The meals served on the two days of audit matched the menu plan approved by the dietitian. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The interRAI assessment process and assessments as part of the electronic care planning system inform the development of the resident’s care plan. The care plans reviewed were resident-focused, however not all interventions were reflective of current needs of the residents. This is an ongoing area for improvement.  Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. The care plans for the younger residents documented interventions associated with a younger person. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Residents interviewed reported their needs were being met. Family members interviewed stated their relative’s needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours. The hospice nurse noted ongoing improvement to care and support over the past year. Woodhaugh have purchased a syringe driver.  There were four wounds (two skin tears, one abrasion and one blister) and two pressure injuries being treated on the day of the audit.  The pressure injuries comprised of one resident with a facility-acquired stage two pressure injury; and one resident with a stage two pressure injury acquired from another facility. There was limited wound assessments or description of two of the wounds; limited instructions in wound care plans for two of the wounds. Advised that the wound charts on the electronic system are being reviewed to be more user friendly. There was evidence of the wound care specialist having involvement with wounds. The previous audit shortfall continues to require improvement.  The GP is involved with clinical input for wounds and pressure injuries and the wound care specialist nurse is accessed as required. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.  Staff interviewed stated that there were adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources (sighted). A continence specialist can be accessed as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a diversional therapist who works 34 hours per week Monday to Friday; and a community facilitator who works 11 hours per week.  Activities to address the abilities and needs of different residents (rest home and hospital) are offered. A wide range of group activities include walking groups, reading, drawing, sing-along, movie time, news and views, brain games, housie and high teas. On Saturdays the community facilitator facilitates a board game activity session. On Sundays one of the residents runs a DVD session. A shuttle service provides transport for outings. Community involvement includes visits from community singing groups. At times residents will be taken on one-to-one visits for shopping or appointments. Students from Otago Polytech visit the facility and provide foot massages to residents.  One of the younger residents loves art and the artwork is displayed in the facility.  The diversional therapist completes an assessment for each resident and an activity plan is completed on admission. A record is kept of individual resident’s activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.  Resident meetings are chaired by a member of Age Concern, who also visits residents on a one-to-one basis. Feedback from residents about the activity programme occurs one-to-one and in group settings.  Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. The diversional therapist has a current first aid certificate. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Registered nurses evaluate all initial care plans within three weeks of admission. Care plans sampled demonstrated long-term care plans were evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files sampled. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building warrant of fitness expires 18 February 2020. The facility employs a maintenance person to undertake maintenance and a gardener/cleaner who maintains the grounds. Daily maintenance requests are addressed, and a 12-monthly planned maintenance schedule is in place. Electrical testing has been completed within the last year. Annual calibration and functional checks of medical equipment is completed by an external contractor and was completed on the day of the audit. Heat pumps are in place throughout the building which provide heating.  Hot water temperatures in resident areas are monitored monthly. Contractors are available 24 hours for essential services.  The facility has several small and large lounges and enough space for residents to safely mobilise using mobility aids. Outdoor areas are easily accessible to residents and seating and shade are provided.  The HCAs interviewed, stated they have enough equipment to safely deliver the cares as outlined in the resident care plans.  Room 53 was verified as a double room, this room/apartment has an ensuite bathroom and adequate space for both residents (married couple) to move around with aids. There were two call bells within easy reach of the residents.  The Gables wing (upstairs) is not currently occupied and renovations continue. This is an ongoing improvement. There are adequate toilet and shower facilities. However not all signage was in place and maintenance had not always occurred in the shower areas. |
| 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 | Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator (interim CM with assistance from RNs) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is logged onto the electronic system and a monthly report is generated and relevant information is given to staff. Definitions of infections are in place appropriate to the complexity of service provided.  Infection control data is discussed at monthly staff meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule.  There was one suspected outbreak since the previous audit. The outbreak was well managed and documented, all notifications were made in a timely manner. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. Staff have received training around managing behaviours that challenge. |

# 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 | There is an internal audit schedule to cover clinical aspects of care, food services, fire and evacuation, and infection control. The health and safety audit was scheduled to be completed in August. All internal audits completed have corrective actions in place which have been signed off and discussed at meetings. Staff interviewed can identify audits and corrective actions discussed at meetings, however not all audits have been completed according to the schedule. The facility manager can describe the corrective action and catch up plan to rectify this. The environmental audit is currently being reviewed to be more meaningful. The maintenance audit was scheduled for August. | i) Internal audits not completed according to schedule. No audits have been completed in July or August (to date of the audit)  ii) There has been no environmental audit completed since the last audit. | i) Ensure internal audits are completed according to the schedule.  ii) Ensure an environmental audit is completed.  180 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | Electronic progress notes were maintained in five if six files reviewed. All healthcare assistants document progress notes against the care plan interventions, including changes in resident condition. Registered nurses document in all residents notes according to legislation and demonstrate follow-up of residents change in condition or following incidents. Contact with relatives is documented in the progress notes. | One rest home resident did not have documentation regarding a fall occurring outside of the facility where the resident sustained a fracture. | Ensure progress notes are maintained following all incidents and changes in condition.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | There were interventions in place to instruct healthcare assistants to care for the needs of residents. The interventions documented were individualised to each resident. Healthcare assistants interviewed were knowledgeable around the individual care needs of residents and could describe the care they provide. Healthcare assistants reported they are updated with changes in condition or further instructions required to care for residents at the time of handovers, however not all care plans were reflective of current needs of the residents. | ii) There were no interventions on the care of a plaster cast for the rest home level resident on respite care.  ii) Interventions lacked detail on personal cares/showering for a complex hospital level resident.  iii) There was no signs or symptoms or management plan for a hospital level resident dependent in insulin.  iv) There were no interventions on bowel cares and management of constipation for a hospital resident with complex needs.  v) Interventions did not reflect recommendation by the GP for a hospital level resident.  vi) There were no interventions around skin integrity including support for residents with current wounds. | (i)-(vi) Ensure all interventions in long-term and short-term care plans are reflective of current needs of residents.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | All residents have a care plan in place. Monitoring charts were in use and sighted for Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours. However, there was a shortfall identified around the documentation of a turning chart for one resident. There were six wounds currently being managed including two grade 2 pressure injuries. There was limited wound assessments or description of two of the wounds; limited instructions in wound care plans for two of the wounds. Advised that the wound charts on the electronic system are being reviewed to be more user friendly. | (i). The repositioning chart for one hospital resident with a pressure injury was not completed as required to provide evidence that the resident had been re-positioned as specified in the care plan. (ii) Two of the wounds had inadequate assessment or description and there were inadequate wound care plans in place for two of the wounds | (i) Ensure that re-positioning charts are completed and that residents are re-positioned at the frequency specified in their care plan.  (ii) Ensure that wound assessments are adequate and wound care plans are in place for all residents with wounds.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | There is a current building warrant of fitness that expires 18 February 2020. There is a preventative and reactive maintenance programme in place. The upstairs area (level one Gables wing) is not currently in use as it is in the process of refurbishment. | The renovation of the upstairs area is not complete, examples include flooring for toilet and other areas, accessible ramps and heating. | Complete the renovation of the upstairs area; flooring for toilet and other areas, accessible ramps and ensure heating prior to admission of hospital residents (and rest home residents).  Prior to occupancy days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | Residents were observed to be moving freely around the building. There are ramps in place and wheelchair access to all communal areas, there are adequate toilet and shower facilities. However not all signage was in place and maintenance had not always occurred in the shower areas. | (i) There was no signage on one toilet. (ii) One resident stated they felt cold in the North wing. (iii) One toilet had no lock in place. (iv) Paint was peeling on the floor of one shower. (v) One shower had a rusty handrail, and another had no handrails. (vi) No call bell cords for residents to reach when in bathrooms independently | (i)-(vi) Ensure all shower and toilet areas are compliant with current legislation.  90 days |

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

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

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

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

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End of the report.