

Maniototo Health Services Limited - Maniototo Health Service

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

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| Legal entity: | Maniototo Health Services Limited |
| Premises audited: | Maniototo Health Services |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 1 October 2019 End date: 2 October 2019 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 26 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Maniototo Health Services Limited provides care for up to 31 residents requiring rest home or hospital level of care. On the first day of the audit there were 26 residents residing at the facility.

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

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

The requirement for improvement from the May 2017 certification and partial provisional audit relating to complaints has been partially closed. The requirement for improvement from the Dec 2018 surveillance audit relating to policy reviews remains open.

The requirements for improvement from the February 2019 partial provisional audit relating to: staff training and competencies; nursing progress notes and interRAI assessments; medical plans of care; short-term care plans; medicines management system; medication competencies, self-administration of medicines and, call bell system have been closed.

There are additional areas requiring improvement from this audit relating to: policy implementation; quality management system implementation; service provision timeframes; and adverse event management.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Some standards applicable to this service partially attained and of low risk. |
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is made available to residents and families.

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

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

There has been one complaint forwarded to the Health and Disability Commissioner since the last audit.

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. |
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Maniototo Health Service Limited is governed by a board of directors. The mission, objectives and values of the organisation are included in business planning documentation.

Quality and risk performance is monitored and reported. Corrective action plans from quality activities are documented, with evidence of the resolution of issues. Organisational risks and controls are clearly documented.

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

Maniototo Health Service Limited has implemented human resource policies and procedures. Practising certificates for staff who require them are validated annually. An annual training plan is implemented to ensure ongoing training and education for all staff members.

A review of rosters and service delivery staff, as well as resident/family interviews confirmed that there is sufficient staff available.

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

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

The service uses both electronic and hard copy medication charts. Training and education in medication management has been provided and staff have completed medication competencies. There were no residents self-administering medicines during the on-site audit.

The service has a contracted service provider for provision of food services. Residents were satisfied with the meal 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. | | Standards applicable to this service fully attained. |
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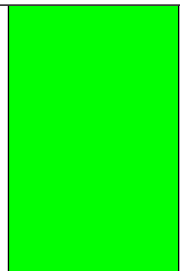
The facility relocated to new premises in April 2019. There is a current certificate of public use for the facility. Call bells are in place and responded to promptly.

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. |
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The restraint coordinator' role is shared by two clinical nurse managers. On the day of the audit there were no residents requesting the use of enablers and one resident using restraint.

Infection prevention and control

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| <p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p> |  | <p>Standards applicable to this service fully attained.</p> |
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The infection coordinator role is shared by two clinical nurse managers. Surveillance for infections is undertaken monthly. The infection surveillance results are reported to staff and management.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 0 | 14 | 0 | 3 | 1 | 0 | 0 |
| Criteria | 0 | 35 | 0 | 4 | 1 | 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) |
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| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>PA Low</p> | <p>The organisation's complaints/concerns management policy outlines the complaints procedure that is in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The complaints policy includes the expected timeframes for responding to a complaint and the process by which verbal complaints will be managed, including that the staff member receiving the complaint should complete a complaint form. A complaints form is available on which to document the complaint, actions taken and sign off. However, these had not been completed for the complaints sighted. The previous requirement for improvement relating to a verbal complaints process has been partially closed out.</p> <p>The complaint process and forms are made available as part of the information provided to residents and their families on entry to the service and available in prominent places throughout the facility.</p> <p>The general manager (GM) is responsible for managing complaints. A complaints register is in place that includes: the date the complaint is received; a description of the complaint; when the investigation was undertaken; resolution and the date the complaint is signed off. There had been three complaints documented on the register since the previous audit, including two verbal complaints. Verbal complaints received by staff or raised at resident meetings are documented in a communication book and included on the complaints register. The previous requirement for improvement relating to verbal complaints being documented on the register has been closed out.</p> <p>The complaints reviewed indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> |

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| | | <p>Staff, resident and family interviews confirmed that residents and family are able to raise any concerns and provide feedback on services. Residents and family stated that whilst they were not aware of the complaints process, they were aware that they could make a complaint and felt comfortable raising issues directly with the GM or CNM. Resident interviews confirmed an awareness of their rights to advocacy. The complaints process confirmed for residents the contact details of advocacy services in relation to the complaints process if necessary.</p> <p>There had been one complaint lodged with the Health and Disability Commissioner (HDC) regarding resident care. Maniototo Health Services Limited (Maniototo Health Services) has provided a response as requested to the HDC and is awaiting the outcome. This complaint had not been added to the complaints register.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>There is an open disclosure policy that sets out the process to guide staff to ensure that adverse, unplanned and untoward events are addressed in an open manner. Completed accident/incident forms and corresponding resident records demonstrated that family are informed if the resident has an accident/incident; a change in health or a change in needs. Resident and family interviews confirmed that family are informed of any changes in resident status and that family have input into resident care planning.</p> <p>Quarterly resident meetings inform residents and family of facility activities and provide an opportunity to raise and discuss issues/concerns with management. Upcoming meetings are identified on the facility activities plan and residents are reminded verbally by the diversional therapist. Family are also invited to attend upcoming resident meetings by email. Minutes of the residents' meetings sighted evidenced that a wide range of subjects are discussed including but not limited to: food service; staffing; call bells; issues such as transferring calls to portable telephones; refurbishment of the adjoining building; audit results; and relevant policies and procedures.</p> <p>Residents and family are provided with copies of upcoming planned activities and the menu. Resident and family interviews identified that they feel comfortable approaching the clinical nurse managers (CNM) with any of their concerns or queries and that these are responded to promptly.</p> <p>There is policy that provides guidance and procedures for staff to ensure that residents who do not use English as their first language are offered interpreting services. The policy provides staff with contact details for local interpreters. At the time of the on-site audit there were no residents who required interpreters.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated,</p> | FA | <p>Maniototo Health Service's business plan documents the organisation's mission, objectives and values. The business and strategic plans outline the strategic direction for the organisation.</p> <p>The monthly management reports provide the board with progress against identified indicators.</p> <p>The facility has a general manager (GM) who is supported by two part time clinical nurse managers (CNM). A general practitioner (GP) provides clinical leadership.</p> |

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| <p>and appropriate to the needs of consumers.</p> | | <p>The GM has been in the role for over 12 years and has previous organisational management and finance experience.</p> <p>The two CNMs share the CNM role providing a total of 1.2 FTE as CNM. The CNM have identical position descriptions and allocated different additional responsibilities, such as infection control and restraint. The CNMs work together one day per week to allow for handover and discussion of residents. One CNM has been working in the facility for 32 years, initially as a hospital aide and for the last 14 years as a registered nurse (RN). The other CNM has been with the facility as a RN for four years and is a qualified counsellor with previous experience working in aged care facilities and as a nurse tutor and counsellor. Both CNMs have been in the role for one year and hold current annual practising certificates.</p> <p>Maniototo Health Service provides services in dual purpose beds for up to 31 residents. These are made up of a 16 bed dual purpose wing with 6 acute medical beds and 10 beds for hospital level residents. A second 15 bed dual purpose wing is allocated for rest home residents and hospital residents. The facility is certified to provide hospital services - medical services; hospital services - geriatric services (excluding psychogeriatric); and rest home care (excluding dementia care).</p> <p>The facility has contracts with the district health board (DHB) for the provision of rest home and hospital level care; respite care; palliative care; younger persons with disabilities (YPD) services and acute medical inpatient care. At the time of the on-site audit occupancy included 11 residents requiring hospital level care (geriatric) and 13 residents requiring rest home level care. In addition, there was one resident under the medical inpatient agreement and one resident referred by the local needs' assessment service for carer support.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>PA Low</p> | <p>Maniototo Health Service has documented quality and risk management frameworks that are available to guide service delivery. All quality policies sighted demonstrate evidence of current review. However, clinical policies require review to reflect the appropriate legislation and practice guidelines. The facility has a suite of new quality and clinical documents, that have been developed with the assistance of an external contractor. Outdated documents are removed from circulation, as new documentation is introduced. The previous requirement for improvement relating to document control has been closed out.</p> <p>The new and revised policies have recently been presented to staff to read and comment. Some forms and templates from these documents have been implemented. However, most policies, procedures and guidelines are yet to be fully implemented. The previous requirement for improvement relating to updating policy documentation has been partially closed out.</p> <p>All policy documentation is available to staff in hard copy. Staff interviews and meeting minutes confirmed that staff are advised of new policies and changes to practice. Staff who are not in attendance at meetings, sign to confirm that they have read the minutes.</p> <p>Service delivery is monitored through the organisation's reporting systems, utilising a number of clinical indicators,</p> |

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| | | <p>including, but not limited to: accidents and incidents; falls; skin tears; and medication errors. Results of data collation are analysed for trends and presented and discussed at staff meetings. The previous requirement for improvement relating to the trending and analysis of data has been closed out.</p> <p>There is evidence that the annual internal audit programme is implemented as scheduled. Where required, corrective action plans are developed, implemented and closed out for internal audits. There is communication with all staff of any subsequent changes to procedures and practice through meetings. However, meeting minutes do not clearly demonstrate that corrective actions and items arising from minutes are clearly documented and followed through.</p> <p>A resident and family survey was last conducted in February 2019. The survey demonstrated that most respondents rated the services as either good or excellent. This was confirmed at audit, through resident and family interviews. The previous requirement for improvement relating to the completion of a resident survey has been closed out.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. There is a current and up to date hazard register in place. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly.</p> <p>One CNM has overall responsibility for health and safety and interview confirmed a clear understanding of the obligations of the role. In addition, there are two nominated health and safety representatives. Staff interviews confirmed an awareness of the process and responsibility to report hazards. There is evidence of hazard identification being completed and that hazards are addressed and risks minimised.</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</p> | <p>PA Low</p> | <p>The GM is aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. There have been no essential notifications to any other external agencies. Interview with the GM confirmed notification to HealthCERT of one board member having left and there was evidence sighted to confirm that both new CNM roles have been notified to HealthCERT. The previous requirement for improvement relating to essential notifications has been closed out.</p> <p>A review of documentation confirmed that there is a process for staff to document adverse, unplanned or untoward events on an accident/incident form. Incident reporting forms are available in the staff room. Documented incident forms include a description of the event; corrective actions and follow-up implementation as well as sign off. However neurological observations were not consistently undertaken for residents who had experienced an unwitnessed fall. There is regular instruction and discussion in staff meetings on the accident and incident reporting process and the revised reporting forms. This was confirmed through staff interviews and review of meeting minutes. The previous finding relating to staff training in adverse event reporting has been closed out.</p> <p>Corrective actions arising from incidents are implemented. Information gathered is shared at health and safety</p> |

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| manner. | | <p>meetings. Staff interviews confirmed awareness of the adverse event reporting process and their obligation to documenting untoward events, however, policy and practice do not meet requirements.</p> <p>All equipment is fit for use. The previous requirement that unfit equipment was available for use and surfaces were unsafe has been closed out.</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> | FA | <p>Human resource management policies and procedures meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrated evidence of up to date human resource practices and recruitment processes. These include but are not limited to: reference checks; a police check; position specific job description; and a signed employment agreement.</p> <p>There are two part-time CNMs, each employed for 0.6 FTE, who each share the nurse manager (NM) role jointly providing 1.2 FTE to this position. The GP also provides support and clinical input when required. Interviews and a review of staff files confirmed that the CNMs each have a role specific position description and a signed employment agreement and have completed role specific orientation. The previous requirements for improvement relating to the appointment of the clinical manager to meet contractual requirements and the formal orientation of the CNM role has been closed out.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff who require them. An appraisal schedule is in place and all staff files reviewed, for those who have been employed for greater than one year, evidenced a current performance appraisal.</p> <p>An orientation programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, such as personal cares and health and safety. Staff files confirmed that staff undertake a formal orientation specific to their role. New staff work alongside experienced staff members until fully confident and competent. Care staff confirmed their role in supporting and supervising new staff.</p> <p>The organisation has a documented role specific, mandatory annual education and training module for 2020. Training includes a combination of in-house training and on-line training through the Canterbury DHB. The service has implemented systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. Staff interviews' and training records confirmed that ongoing education is provided. Care staff complete annual competencies, including cardiopulmonary resuscitation training, with 24 of 26 staff members having completed first aid training, one CNM is Primary Response in Medical Emergencies (PRIME) trained, and 17 staff members have completed medication competencies. There are four of nine RNs, including one CNM, who have completed interRAI assessments training and competencies. Interviews and training records reviewed confirmed that all care staff, including RNs, undertake at least eight hours of education and training hours per annum. The previous requirements for improvement relating to the implementation of the annual training plan</p> |

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| | | and staff completing training and competencies, have been closed out. |
| <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> | FA | <p>The facility currently has 48 staff consisting of: a management and administration team; RNs, enrolled nurses; care givers; a diversional therapist; a maintenance person and household staff. Household staff include cleaners and kitchen staff, who along with carers provide household services seven days a week.</p> <p>The organisation's staffing levels and skill mix policy provides guidance to ensure safe staffing levels within the facility meet the needs of residents' acuity and the minimum requirements of the DHB contract. Rosters are formulated four weeks in advance and staffing levels are reviewed and adjusted as required due to changes in the number or acuity of residents, such as additional hospital level residents or acute medical patients. There is a team of casual staff available to supplement rosters when needed to accommodate increases in workloads.</p> <p>There are sufficient RNs and carers available to safely maintain the rosters for the provision of care. The CNMs each work three days per week on morning shift covering Monday to Friday, with an overlap on one day per week, typically Wednesday. In addition, there is at least one RN on each morning, afternoon and night shift, seven days per week. There are: four care staff or enrolled nurses, plus a bath assistant who works a three-hour short shift on duty each morning shift; two care givers on afternoon shift, plus a three-hour tea shift; and one care giver on night shift. There are adequate staffing levels to meet current resident acuity and bed occupancy.</p> <p>There is no on call roster, however, interviews confirmed that both CNMs and/or RNs can be called after hours, seven days a week, with staff living closest to the facility likely to be called in the first instance. The GP is on call for after-hours throughout the week. There is a memorandum of understanding in place with Dunedin Hospital for telephone support to the facility. Staff can also seek support and assistance in a medical emergency from an on-site PRIME nurse who is available some weekends from Friday evening through to Monday morning and/or St John's Ambulance service.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Resident and family interviews stated that staffing is adequate to meet the residents' needs. Staff interviews stated that whilst they are busy at times they have sufficient time to complete their scheduled tasks and resident cares.</p> <p>The facility has one dedicated nurses' station centrally positioned and within easy access to the two wings.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p> | FA | <p>The service has an electronic medication management system at the facility for rest home and hospital residents and hard copy medication files are used for medical admissions to the facility. The medicines are supplied by a contracted pharmacy. Safe medicine administration was observed at the time of the audit. The medication register recorded weekly checks and six-monthly stocktakes. The medication refrigerator temperatures are monitored and recorded weekly and are within the recommended temperature range.</p> |

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| <p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>The RNs and HCAs administer the medicines. Staff have had training and education on the electronic medication system and have completed competencies prior to administering medicines.</p> <p>There were no residents self-administering medications on audit days.</p> <p>The standing orders used at the facility are accessible to staff and reviewed annually by the GP.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food service is contracted to an external contractor. Food is transported to the facility, prepared and served by staff. The menus are reviewed by a dietitian. Extra food is available for any acute medical admissions, if required.</p> <p>Dietary assessments are completed for all admissions, are recorded and communicated to the contractor and to staff serving food in the kitchen. The dietary residents' list includes: the types of diets required; residents' likes, dislikes and allergies; preferences of residents having their meals in the dining room or their rooms; size of meals and assistance required. Residents' food preferences and allergies are recorded and staff who serve the food are aware of these. Residents requiring assistance with meals are supported by staff, as observed.</p> <p>Residents reported satisfaction with the meals and fluids provided.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines.</p> <p>The staff working in the kitchen have completed food safety and hand hygiene infection control education.</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>FA</p> | <p>Residents' long term care plans are completed by the RNs and the CNMs. There was evidence of residents and family input into the development of the care plans. Care staff interviews confirmed they read and sign that they have read the care plans and they are knowledgeable of the care requirements of the residents they are allocated to care for.</p> <p>The long term care plan interventions were documented for the rest home and hospital level residents. The care plans are individualised and personalised to meet the specific assessed needs of each resident. The residents reported satisfaction with service delivery.</p> <p>There was evidence of referral to specialist services such as wound care specialist, when required.</p> <p>There are regular and as required medical reviews conducted by the GP. Interview with the GP confirmed that clinical staff inform them of any resident's deteriorating or altered condition and medical reviews are conducted in a timely manner. There was evidence in the medical progress notes this is occurring. Detailed medical notes are provided following medical reviews for long term residents and medical admissions, and these include the required medical plans of care.</p> |

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| | | Nursing observations and nursing care interventions that are required for the assessed condition are conducted and recorded (refer to 1.2.4.3 and 1.3.3.3). |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>There is a planned activities programme for both the rest home and hospital residents, which is provided from Monday to Friday each week. The monthly activities programme is developed by the diversional therapist. A daily activities programme is displayed at the facility. The service has links with other community organisations, churches and local schools.</p> <p>Residents are free to choose whether they wish to participate in the activities provided. Residents are encouraged to maintain links with the community through outings with family.</p> <p>Residents' attendance and participation is documented. Evaluations are completed six-monthly with nursing review and there is evidence of resident and family participation.</p> <p>The diversional therapist completes residents' activities assessments and reviews the activities assessments. Review of the activities care plans evidenced detailed and individualised activities relevant for the resident.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated on each shift and reported in the progress notes. When changes are noted it is reported to the RN or the CNM, as confirmed at care staff interviews.</p> <p>Residents' long term care plan evaluations occur every six months. The care plan evaluations record the achievement of the residents' goals and the degree of achievement to the support/interventions provided. Short term care plans are completed for short-term problems (refer to 1.3.3.3).</p> <p>Interviews with residents and family confirmed they are included and kept up to date with any changes.</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> | FA | <p>The facility relocated to the new purpose-built premises in April 2019. A current certificate of public use, issued February 2019, is displayed in the foyer of the facility. No additional building alterations have occurred since the last audit.</p> |

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| <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>Hot water temperatures in areas accessed by residents are monitored at the outlet weekly and were noted to be maintained within recommended temperature ranges. Interview with the maintenance person confirmed that where temperatures varied from the recommend range and corrective action is taken to ensure the water temperature is maintained within the recommended ranges. There is one tap used to dispense boiling water for drinks sited in a communal resident lounge. This has been fitted with a second safety dispensing lever to minimise the risk of accidental burning and has been included in the hazard register. The previous improvement relating to hot water has been closed out.</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>There are call bells to summon assistance in all residents' rooms and toilets of the facility that are also linked to staff pagers. An automated self-checking process within the call ball system is in place, and in addition, manual checks are made weekly. The previous improvement relating to the call bell system has been closed out.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified</p> | <p>FA</p> | <p>The infection control coordinators role is job shared between the two CNMs. Interview with CNMs confirmed a system is in place to monitor and record infection events. The infection prevention and control (IPC) policies and procedures align with the IPC standards (refer to 1.2.3.3).</p> <p>The service conducts monthly surveillance for infections for the service. Review of the rest home and hospital residents' clinical records evidenced that the infections identified and treated had a short term care plan completed (refer to 1.3.3.3).</p> <p>The infection control coordinator interviewed, confirmed there had been no outbreaks since the previous audit.</p> <p>The previous area identified as requiring improvement at the last surveillance audit has been implemented and the</p> |

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| in the infection control programme. | | surveillance of infections is carried out according to the standard. |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | <p>The restraint's coordinators role is shared between the two CNMs.</p> <p>Restraint minimisation and safe practice (RMSP) policy has been reviewed and complies with legislation (refer to 1.2.3.3).</p> <p>At the time of the audit there were no enablers requested for use by residents and one resident was using restraint. Restraint minimisation is included in staff orientation/induction processes and on- going staff education.</p> <p>The previous area identified as requiring improvement at the last surveillance audit has been implemented.</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) |
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| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | Complaints are recorded on the complaints register. These include verbal complaints received by staff or raised at resident meetings that are documented in a communication book and added to the complaints register. However, the complaints process was not followed consistently. | <p>i) A complaint form had not been completed for all complaints.</p> <p>ii) Not all complaints had been included in the complaints register and folder.</p> | <p>Ensure a complaints form is completed for each complaint, that includes the detail of the complaint, investigation, actions taken and sign off and all complaints are documented in the complaints register.</p> <p>90 days</p> |

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| <p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p> | <p>PA Low</p> | <p>A suite of new and revised policies and procedures have been developed to replace the existing quality and risk management system and outdated clinical procedure documentation. The service had commenced implementation of the new documentation, however this was incomplete.</p> | <p>The suite of new policy and procedure documentation had not been fully implemented.</p> | <p>Ensure full implementation of all new policy and procedure documentation.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | <p>PA Low</p> | <p>Corrective action plans are: developed; implemented; and closed out from internal audits. There are regular staff meetings, that demonstrate a range of items are discussed such as but not limited to; incident forms; medication; internal audits; wound care and care planning. However, minutes do not consistently identify that corrective actions and items carried forward from meetings are clearly documented in minutes and followed through.</p> | <p>Meeting minutes from staff meetings do not clearly identify that corrective action plans are developed; implemented; and closed out or that items arising from previous meetings are carried forward.</p> | <p>Ensure that corrective actions and items arising from meetings are clearly documented, identifying timeframes, responsibilities and close out.</p> <p>90 days</p> |
| <p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to</p> | <p>PA Low</p> | <p>There is a process and training to support staff to document adverse, unplanned or untoward events on an accident/incident form. Interviews confirm that the accident and incident reporting procedure and requirement for neurological observations is regularly enforced. Staff interviewed understood the adverse event reporting process and their obligation to documenting untoward events.</p> <p>The process for unwitnessed falls includes that the resident is asked to</p> | <p>i) The policy for identifying a potential head injury following an unwitnessed fall does not reflect best</p> | <p>i) Revise the adverse, unplanned or untoward events policy to ensure neurological observation occur following all</p> |

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| <p>identify opportunities to improve service delivery, and to identify and manage risk.</p> | | <p>identify if they have hit their head in the fall. In which case neurological observations should commence. Policy and procedures for unwitnessed falls does not meet best practice standards. Observations, including neurological observations, are not commenced for all residents who experience an unwitnessed fall.</p> | <p>practice. ii) Observations, including neurological observations, are not undertaken or completed for the required time frames for eight of eight residents who had experienced an unwitnessed fall.</p> | <p>unwitnessed falls. ii) Ensure that neurological observations are undertaken for the required time frames for all residents who experience an unwitnessed fall. 90 days</p> |
| <p>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.</p> | <p>PA Moderate</p> | <p>The residents' nursing, medical assessments, care planning and treatment meet the required timeframes relating to the standards and the ARC contract.</p> <p>i) An area identified at the last partial provisional audit relating to the ARC residents' clinical records evidencing reason for resuscitation decision not always being documented remains open. The written handover form records the residents' not for resuscitation status. Review of nine residents' clinical records relating to not for resuscitation orders evidenced: the residents' that were competent to make a not for resuscitation decision had not signed the four of the nine forms. Two not for resuscitation orders have not been regularly reviewed, one recorded initial order in 2013 with no subsequent reviews and second not for resuscitation form was last reviewed in 2015.</p> <p>ii) There was evidence of wound care plans not recording when wound reviews were due and wounds not being evaluated according to the scheduled evaluation dates when they were recorded. The frequency of wound dressing assessment/evaluations is managed by writing the dressings and the date of reviews on the written handover form. Review of all wounds at the facility evidenced there were five wounds that required regular dressing changes, assessments and evaluations. There was evidence not all wounds requiring photos and measurements had</p> | <p>i) The resuscitation decisions do not always evidence resident sign off and have not been regularly reviewed. ii) Wound assessments and evaluations are not consistently documented or provided at the required timeframes. iii) Short term care plans do not consistently record close out and sign off.</p> | <p>Provide evidence that: i) Resuscitation management complies with legislation and reviews are conducted. ii) Patient wound care is documented and wounds are attended to according to the specified timeframes for dressing changes. iii) Short term care plans are closed out and signed off when</p> |

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| | | <p>these recorded; instruction of the next dressing change were not always recorded; when dressing changes were required they were not always documented that they were completed.</p> <p>iii) Short term care plans are used for short term problems. Review of the short term care plans evidenced when the short term problem had been resolved this was not always documented and signed off.</p> | | <p>short term problems are resolved.</p> <p>60 days</p> |
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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.

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End of the report.