

Calvary Hospital Southland Limited - Calvary Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Calvary Hospital Southland Limited
Premises audited:	Calvary Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 May 2017 End date: 10 May 2017
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:	72

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Calvary Hospital Southland provides hospital and rest home care for up to 80 residents. The service is operated by a trust board and managed by the manager, a registered nurse. Residents and families spoke positively about the care provided.

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

This audit has resulted in three areas requiring improvement relating to medications management and food storage.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Posters detailing the code were displayed in both

English and Māori and leaflets were available. Services are provided that support personal privacy, independence, individuality and dignity. Staff were observed to interact with residents in a respectful manner and this was confirmed upon interviews with residents and family members.


Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required provided by the DHB. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs, and this was confirmed during interview with a Māori resident. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs including mental health, physiotherapy, podiatry and dietitians.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the board is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

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

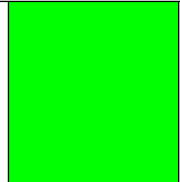
The multidisciplinary team, including registered nurses, the dietitian and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information gathered during the interRAI assessment process, and accommodate any new problems that might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

Medications are safely and appropriately prescribed, stored, reconciled and disposed of according to legislation, protocols and guidelines.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and is clean and well maintained. There was a current building warrant of fitness for the building. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents and family members reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints in use at the time of audit. Twelve bedrails as enablers were being used. All documentation was in place for enabler use. Staff demonstrated a sound knowledge and understanding of the difference between restraints and enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, is led by an experienced and trained infection control coordinator and aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, and verbalised good knowledge of infection prevention strategies upon interview. Infection control practice is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	1	0	1	0
Criteria	0	90	0	1	1	1	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Calvary Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. This was also confirmed during interviews with residents and family members.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained using the organisation's standard consent form.</p> <p>With regard to advance care planning, some files did not have a doctor's signature to verify that the resident was able to make an informed choice as to their wishes. This was rectified in all files on the day of audit. The establishment and documenting of processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Enduring power of attorney requirements and related documentation are held in individual resident records and a separate administrative file located in the administration department. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents and family members are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports a Christian philosophy of love, compassion and caring.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to families on admission and those interviewed knew how to make a complaint if required. One family member interviewed has used the process and confirms the responsiveness of the organisation.</p> <p>The complaints register reviewed showed that five complaints have been received in 2017 and that actions taken, through to an agreed resolution, were documented and completed within the required timeframes. Action plans showed any required follow-up and improvements have been made where possible. The manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The one recent complaint is still in the process of completion, all timeframes have been met.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided to residents and family members once admitted to the facility. Information regarding the Code and Advocacy Service was not however being provided in the information package given to potential new residents. This was discussed and appropriate literature now forms part of the initial</p>

		information provided to all potential residents. The Code is displayed in areas in the form of posters in both English and Māori and there is information available on how to make a complaint.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed during interview that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in the organised activities programme delivered seven days a week. The activities programme focusses on five components of activities which were detailed as individual, emotional, social, physical and intellectual. Activities also include visits to local groups and the RSA. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Staff receive education on abuse and neglect and residents confirmed that they feel respected and well treated.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Calvary Hospital has two residents who identify themselves as Māori. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan. The Māori resident interviewed reported that staff acknowledge and respect individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in all care plans that were reviewed. All residents interviewed confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The organisation operates under a Christian philosophy which was demonstrated to be incorporated in everyday care delivery and management.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies and input from external specialist services and allied health professionals such as mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included frequent handwashing and hand sanitisation, respectful interactions between staff and residents/family and the appropriate use of personal protective equipment (PPE).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and most family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. One family member who specifically asked to speak to the auditors reported that she was unhappy with some communication between herself, the facility and the manager, stating that she had not been informed of untoward events such as when her relative had developed a urinary tract infection (UTI). Other family interviewed stated that they were kept informed of any untoward events and were happy with the level of communication maintained by the facility. Staff interviewed understood the principles of open disclosure, which was supported by policies.</p> <p>Staff know how to access interpreter services through the local district health board, although reported this was rarely required due to all residents being able to speak English. This being the case, staff were still able to provide interpretation if and when required.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. Compassion and the Catholic philosophy are included in all strategic documents. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly manager's reports showed adequate information to monitor performance is reported to the Board including staffing issues, occupancy rates, identified risks and issues, trends and analyses of these.</p> <p>The service is overseen by a manager, a registered nurse, who holds relevant qualifications and has been in the role for over eight years. She is supported by a clinical co-ordinator, also in the role for eight plus years. Responsibilities and accountabilities are defined in job descriptions and individual employment agreement. The manager and clinical co-ordinator confirm knowledge of the sector, regulatory and reporting requirements and maintain currency through attendance at annual conferences and management related education forums.</p> <p>The service holds contracts with the DHB for rest home and hospital care, respite, chronic conditions and palliative care. Seventy-two residents were receiving services under the contracts at the time of audit, including one respite resident. There were twenty nine residents receiving rest home care and forty three residents receiving hospital level of care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the manager is absent, the clinical co-ordinator carries out all the required duties under delegated authority. During absences of the clinical co-ordinator, the clinical management is overseen by the manager with support from the senior registered nurses (RN) at the facility who are experienced and able to take responsibility for any clinical issues that may arise. This arrangement has worked well for many years. Staff reported the current arrangements work well.</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>FA</p>	<p>The service has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, and clinical incidents including infections and restraint use.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff reported their involvement in quality and risk management activities through education and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. There are resident/family satisfaction surveys that are completed annually. The most recent survey showed a</p>

		<p>high satisfaction in the food service, including the breakfast buffet style implemented. One area identified by residents was related to talking in chapel – this has been addressed with notices, education and has since shown a considerable improvement.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. She is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at the management, quality and staff meetings.</p> <p>The manager and clinical co-ordinator both described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events made to the Ministry of Health or DHB since the previous audit. This relates to a current pressure injury and a norovirus outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates, where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. A sample of general practitioner, pharmacist, podiatrist and physiotherapist practising certificates confirmed these were current.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month induction/orientation period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The education</p>

		<p>facilitator is the internal assessor for the programme. Staff have either completed or are enrolled in the required education for services providing rest home and hospital level care. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Annual syringe driver competencies have not been completed (refer to criterion 1.3.12.3). Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A facility staffing policy is in place to alter staffing according to the skill mix and residents' needs. Rosters are the responsibility of the manager with input from the clinical co-ordinator.</p> <p>The service adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there are adequate staff available to complete the work allocated to them. They reported that this facility has a high staff to resident ratio, and absences are routinely covered. Family members interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site in two places. The most recently archived being held near reception and longer term archiving being held in a secured basement. All notes and documents are readily retrievable using a cataloguing system by year of archiving.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process in the form of an information package folder detailing cost, menus, activities, information about the history of the facility, service</p>

<p>identified.</p>		<p>information and frequently asked questions. The organisation seeks updated information for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail and interRAI assessments in accordance with contractual requirements. Signed admission agreements were held in a separate administration folder. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes which were sighted.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA High</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart sighted via the MediMap system in addition to allergies and sensitivities to any medications. Standing orders are not used at the facility.</p>

		<p>There is one resident who self-administers medications at the time of audit (Insulin). Appropriate processes are in place to ensure this is managed in a safe manner including medication competency assessments of the resident every three months which were sighted.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> <p>During audit, evidence of poor practice and noncompliance with safe and appropriate administration of medications was witnessed. The administration practices not complying with policy/procedure and safe practice guidelines. It was also found that competencies to ensure safe and administration of medicines via syringe drivers had not been undertaken.</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>PA Low</p>	<p>The food service is provided on site by an internal chef/cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and a food control plan individualised to the facility. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Resident dietary profiles are kept in the kitchen and any changes are notified to the chef in a timely manner. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>On the day of audit, it was found that food had been decanted into separate containers without correct labelling and that food items, intended for resident consumption had passed their use by date.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as a pain scale, falls risk, skin integrity, nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of five registered nurse or the one enrolled nurse trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process and this was evidenced on review of assessment documentation.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered to a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>

<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>	<p>FA</p>	<p>The activities programme is provided by three activity coordinators working a seven day week roster for activities. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are more frequently re-evaluated if the interventions are viewed as not being effective in addition to being reviewed as part of the formal six monthly care plan review. The activity coordinators review and sign the care plans and reviews in conjunction with the registered nurses. Activity coordinators undertake regular education and briefings on best practice including participation in the monthly diversional therapy group and the Southland training day next due to be held in July 2017.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents interviewed confirmed they find the programme appropriate and stimulating.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a regular GP from a nearby practice, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to podiatry, dietitians and public hospital health specialists. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. This was verified during</p>

		interview with family members and the GP.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 04 February 2018) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas were safely maintained and are appropriate to the resident groups and setting. There are easily accessed outdoor areas that encourage purposeful walking.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required; any requests were appropriately actioned. Families interviewed state that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes separate facilities for staff and visitors. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents' rooms are spacious enough to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur and equipment can be transferred between rooms. Mobility aids can be managed in communal rooms.</p> <p>Rooms were observed to be personalised with furnishings, photos and other items and the service encourages residents to bring in personal items.</p> <p>There was room to store mobility aids such as walking frames safely.</p> <p>There are three double rooms in the facility being shared by two residents. The other five double rooms occupy one resident, and the manager reports this is likely to remain as one resident in these rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. Residents and families interviewed verified that the facility has sufficient space and residents may stay in their own areas or use any of the communal lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is completed on site in a spacious laundry. A survey of residents confirmed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. All chemicals sighted were labelled. Material safety datasheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 24 September 2014. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 23 February 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for residents and</p>

		<p>staff. Water storage tanks are located around the complex, and there is a generator available if required. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond promptly to call bells. There is at least one staff member on duty at all times with a first aid certificate.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents' rooms are provided with adequate natural light, ventilation, and an environment that is maintained at a safe and comfortable temperature. Temperatures are routinely monitored. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the experienced infection control coordinator / registered nurse and, where appropriate the local DHB. The infection control programme and manual are reviewed annually. The policy is currently undertaking a review to reflect a new collation method of infection statistics.</p> <p>Infection control matters, including surveillance results, are reported monthly to the manager and clinical coordinator and copies posted in the staff room. They are also tabled at the infection control and staff meetings. These reports consist of a monthly collation and analysis of infection rates, number of infections, type of infections, antibiotic usage, comparisons by month, feedback to staff and infection control education information. The monthly statistics are broken down into percentages per 1000 bed days. Reports in graph form are also submitted to the Board, detailing facility acquired infections.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed that a period of 48 hours symptom free must be observed before considering returning to work.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>An experienced registered nurse, educated in infection control and previously holding a position of DHB infection control coordinator, is the designated IPC coordinator, whose role and responsibilities are defined in a job description. The IPC coordinator has appropriate skills, knowledge and qualifications for the role. Previously she was the DHB IC coordinator for 12 years. She maintains her own knowledge of best practice and educational requirements by attending the yearly national conference and attends the one day infection prevention and control conference at the local DHB where she has also been a speaker. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and are currently being reviewed to reflect a new collation method of statistics. All policies include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions, including the use of an infection prevention and control handbook devised by the facility. Education is provided by suitably qualified registered nurse who is the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when following a Norovirus outbreak in April 2016.</p> <p>Comprehensive education on outbreak management (records sighted) was conducted in September and November 2016, including isolation and the correct use of PPE. Hand hygiene</p>

		<p>education forms part of the orientation process for new staff and the facility has developed an infection control booklet devised for both clinical and non-clinical staff which is completed on a yearly basis. This booklet identifies the manager, infection control coordinator, the location of the IC manual, instructions on effective hand hygiene and standard precautions.</p> <p>The housekeeping staff have received education on effective cleaning for the prevention of and management of infections during an outbreak, including outbreak management plans. The IC coordinator has also developed isolation management trolleys designed to reduce the risk of spreading infections. These trolleys contain education and information materials, PPE and antibacterial hand hygiene products. The housekeeping staff are currently trialling the use of microfiber cloths as an infection prevention tool.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and alerting staff if experiencing symptoms.</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 in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. Reports are sent to the manager, clinical coordinator, posted in staff rooms and graph analysis sent the board.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the manager, clinical coordinator and IPC committee.</p> <p>Previous case logs of infections were available and there have been no outbreaks since April 2016 following which the IC coordinator discussed actions to be taken in staff forums and with management, including the outbreak management plan contained in the IC manual. Learnings from the event have now been incorporated into practice, with additional staff education implemented, including education sessions for non-clinical staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the clinical co-ordinator and provides support and oversight for enabler and restraint</p>

<p>restraint is actively minimised.</p>		<p>management in the facility. This person demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and twelve residents were using enablers. The enablers in use were bed rails for safety while in bed. Two files reviewed showed documentation in place was current and reflected the organisation's policies.</p> <p>The facility has not used any restraint in the past three years.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA High	<p>At the time of audit, two registered nurses were seen to have removed individual residents / patients blister pack doses and placed these blister packs in a separate receptacle. This was observed initially at the end of one medication round and, to ascertain if this was common practice and a systematic failure to adhere to best practice guidelines, auditors attended the clinical room prior to a second medication round commencing. Both registered nurses confirmed that these removed blister packs were intended for, or had been used for resident administration. This practice is not reflective of policy/procedure and increases the risk of medication errors.</p> <p>The second registered nurse interviewed also intended to use two blister medications (Warfarin) prescribed for one resident to give to another resident. The original resident's name on the two blisters having being crossed out and the second resident's name (a shortened version and not the resident's full name) handwritten on the back of the blister. The registered nurse interviewed also intended to administer this Warfarin dose without being in receipt of</p>	Registered nurses administering medication are not complying with policy/procedure or best practice guidelines and this is increasing the risk of a medication error occurring.	<p>Provide evidence that all aspects of medication management, including adherence to administration policy/procedure, meets current legislation and best practice guidelines.</p> <p>30 days</p>

		a current INR. The RN has been stood down from medication administration until further medication competency is undertaken.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>RN training records and competencies were reviewed. Syringe driver training is provided to registered nurses on an annual basis as part of the RN training programme. Drug calculations and medication competencies are completed by all registered nurse files reviewed annually. One resident was receiving medications via a syringe driver at the time of the audit. The registered nurses administering medication via a syringe driver did not have a current syringe driver competency. Syringe drivers have not been a routine competency for at least the past two years. There have been no syringe driver errors in the past two years.</p>	<p>The registered nurses at the facility administer medication via syringe drivers, but do not have a current competency.</p>	<p>Provide evidence that all aspects of medication management, including documented syringe driver competencies, meets current legislation and best practice guidelines.</p> <p>60 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>On the day of audit, it was found that dried food had been decanted and labels were not present on all containers to indicate the product within, the decant date of the expiry date. Dried food in the original packaging was found to be present on shelves that had passed the stated best before date.</p>	<p>Dried food is being decanted into clear containers without the expiry date, decant date or product being documented. Food items stored are not being sufficiently checked for expiry or best before dates.</p>	<p>Provide evidence that all aspects of food safety management, including storage and disposal, meets current legislation and best practice guidelines.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.