Presbyterian Support Central - Longview Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Presbyterian Support Central
Premises audited:	Longview Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 November 2018 End date: 21 November 2018

Proposed changes to current services (if any): The number of resident rooms has decreased from 60 to 58. Two resident rooms have become part of the site access to the new build currently under construction.

Total beds occupied across all premises included in the audit on the first day of the audit: 44

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

Longview is part of the Presbyterian Support Central organisation and provides rest home and hospital (geriatric and medical) level care for up to 58 residents. On the day of the audit, there were 44 residents.

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

The service is managed by a facility manager who has been in the role three months, and has a background in the public service and aged care. She is supported by a clinical nurse manager with many years' experience in aged care. The management team is supported by a regional manager.

The residents and relatives interviewed all spoke positively about the care and support provided under the new management team.

Five of the ten shortfalls from the previous audit have been addressed around meeting minutes, adverse events, activities, food storage and call bells have been addressed. There continues to be an improvement required around complaints management and register, corrective actions, performance appraisals and implementations of care.

This audit identified improvements required around the internal audit schedule and interRAI training.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Policies are implemented to support residents' rights, communication and complaints management. Family are involved in the initial care planning, provided health status occurs. Information on the complaints process and advocacy are visible in the care centre. Residents and relatives interviewed were aware of the complaints process.

Policies are implemented to support residents' rights, communication and complaints management. Family are involved in the initial care planning, provided health status occurs. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

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

Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents and infections results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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.

Registered nurses are responsible for each stage of provision of care. Assessments, care plans, interventions and evaluations have been completed. Residents and family interviewed, confirmed that the resident's needs/supports were being met. There is allied health professional input into the resident's care.

Planned activities are appropriate to the resident's assessed needs and abilities for rest home and hospital residents. Activities are varied, interesting and meaningful for the residents as evidenced on resident/relative interviews.

Medications are managed and administered in line with legislation and current regulations. Registered nurses and enrolled nurses responsible for medication administration have completed annual competencies. The general practitioner reviews medication charts at least three monthly.

Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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.

The facility has a current building warrant of fitness. There is a reactive and planned maintenance programme.

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.

There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were three residents with restraints and one resident using an enabler. Consents, assessments and evaluations had been completed as per policy. Restraint minimisation and enabler use training is included in the training programme.

Infection prevention and control

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

The infection control nurse has overall responsibility for the monthly collation of events. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	2	3	0	0
Criteria	0	35	0	3	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Moderate	There is a complaints policy to guide practice and this is communicated to residents and family members. A copy of the complaint's procedure is provided to residents within the information pack at entry. The facility manager leads the investigation and management of complaints (verbal and written). Complaint forms are visible around the facility. Six complaints (two in 2017 and four in 2018 year to date) have been made since the last audit in August 2017. The complaints reviewed have been acknowledged and investigated, however there is no documented evidence in three of six complaints reviewed that the complainants have been informed or are happy with the complaint outcome/result. The previous finding has not been addressed and continues to be an area for improvement. One of the complaints from 2018 was made through the HDC in March, which was followed up, investigated and closed off, however the complaint had not been documented on the complaint register. The previous finding has not been addressed and continues to be an area for improvement.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	There is an open disclosure policy. Four residents (three rest home and one hospital) and two relatives (one rest home and one hospital) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed for November 2018, identified family were notified following a resident incident. Interviews with six HCAs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Resident and family meetings

provide an environment conducive to effective communication.		occur every three months. Enliven-wide and staff newsletters are produced on a regular basis.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Longview Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital (geriatric and medical) level of care for up to 58 residents. On the first day of the audit there were 44 residents. There were 25 rest home residents, including two residents on respite care and one resident under 65 years of age admitted under a 'like in age and interest' contract and 19 hospital residents. All beds are dual-purpose. All other residents are under the age-related residential care (ARRC) contract. Longview Home has a 2018/2019 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior management team meeting. The facility manager been in the role for three months and has previous management experience within the aged care industry. The facility manager is supported by a clinical nurse manager who has been in the position for five and a half months and has over 30 years' experience in the aged care industry. The management team are supported by a regional manager who was present at the time of the audit. The facility manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	Presbyterian Support Central has an Enliven quality management system in place that includes internal benchmarking with the other PSC sites. There is an annual meeting schedule including senior team, staff, clinical/RN and health and safety meetings. Schedules of meetings has been made available for staff and recommenced in March 2018. The meeting schedule has been adhered to since then and topics relating to internal audits, HR issues, CAP updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, restraint infection control, incident data, education/training and business plan goals are discussed. The previous shortfall around staff meetings has now been addressed. The senior team meeting acts as the quality committee and progress with the quality programme/goals are monitored and reviewed through the alternate fortnightly senior team one and two meetings. Meeting minutes and reports are provided to the senior team meeting and actions are identified in quality improvement forms, which are being signed off and reviewed for effectiveness. There is an annual internal audit calendar in place, however not all internal audits for 2018 (year to date) have been completed as per the required schedule. Corrective action plans were not consistently documented and implemented where improvements were identified. The previous shortfall continues to be an area for improvement.

		Monthly collation of accident/incident data and analysis is shared with staff (discussed at the three-monthly staff meetings and placed on the noticeboard in the staff room). The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service, ensuring staff are kept up to date with the changes. The service has a health and safety management system, and this includes a health and safety representative (facility manager) that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee meeting. There is an up-to-date hazard register in place. A resident/relative satisfaction survey is completed annually. The October 2017 survey informed an overall satisfaction with the service at Longview Home at 85% for the relatives and 80% for the residents surveyed. Improvements established in areas identified, relating to laundry, food/meals and activities were followed up and completed. The 2018 resident/relative satisfaction survey results were not available at the time of the audit. Falls prevention strategies are in place and include intentional rounding, sensor mats, post falls reviews and individual resident interventions.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Twelve incident forms for Longview Home were reviewed. All incident forms have been fully completed and residents reviewed by a registered nurse (RN). Neurological observation forms were documented and completed for six unwitnessed falls with potential head injuries sampled. Two pressure injuries reviewed had been documented on an incident form. The previous shortfall around pressure injury documented on incident forms has now been addressed. Discussions with the facility manager and clinical nurse manager and confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 notifications have been completed since the last audit. One for a pressure injury (unstageable) in January 2018, one pressure injury (stage four) in May 2018 and one for having no RN cover (night shift from 11.30 pm to 8.00 am) in August 2018.
Standard 1.2.7: Human Resource Management Human resource	PA Low	There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. Five staff files were reviewed (one clinical coordinator, one RN, two HCAs and one recreation officer) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and orientation checklists. Missing was evidence of up-to-date annual performance appraisals, although the service is working

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		through addressing this as part of a corrective action plan. This previous audit shortfall has not been fully addressed and continues to be an area for improvement. A copy of qualifications and annual practising certificates including RNs, general practitioners (GP) and other registered health professionals are kept. The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. There is an annual education and training schedule in place for 2018. The service provides regular in-service education, and sessions have been provided that address all required areas. Mandatory training for RNs was recommenced in May 2018. Syringe driver competencies completed by RNs in June 2018. There are five RNs, and four are interRAI trained, however not all interRAI assessments have been completed (link 1.3.3.3).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager, clinical nurse manager and clinical coordinator all work full-time. Registered nurses cover each 24-hour period in the hospital unit. Agency staff are used to provide cover for sickness if necessary. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents. Staffing levels are benchmarked against other PSC facilities. In the hospital unit (24 beds) there were 18 residents (17 hospital and one rest home). There is a unit coordinator (RN) who is supported by a RN on the morning, afternoon and night shifts. The RNs are supported by four HCAs (two long and two short shifts) on the morning shift, three HCAs (one long and two short shifts) on the afternoon shift and one HCA on the night shift. In rest home unit (34 beds) there were 24 rest home and two hospital residents. There is an enrolled nurse (EN) who is supported by the clinical nurse manager who is located in the rest home unit. There are three HCAs (two long and one short shift) on the morning shift, three HCAs (one long and two short shifts) on the afternoon shift and one HCA on the night shift. The RNs from the hospital unit cover the rest home unit on the afternoon and nights shifts.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with	FA	The medication management policies and procedures comply with current medication guidelines. Registered nurses and enrolled nurses who administer medications have completed medication competences and education on an annual basis. There are HCA medication competent checkers for the night shift. The service uses robotic rolls which are checked on delivery by a RN, and date of checking is entered into the electronic medication system. Medications are stored safely in one main medication room. There is a hospital stock for hospital level residents. The hospital stock and 'as required' medications are checked monthly for expiry dates. Medication fridges are monitored weekly. All eyedrops in the medication trolleys had been dated on opening.

current legislative requirements and safe practice guidelines.		There were three rest home residents self-medicating and their competencies had been reviewed three monthly. Ten medication charts (four hospital and six rest home) were sighted on the electronic medication system. All prescribing of regular and 'as required' medications met legislative requirements. The general practitioner reviews medication charts at least three-monthly. 'As required' medication was administered as prescribed and the effectiveness entered into the electronic medication system and progress notes.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site in the main kitchen that is adjacent to the main dining room. The food service team leader is a qualified chef and is supported by a weekend cook and morning and afternoon kitchenhands. There is a five-weekly rotating summer menu in place that has been reviewed by a dietitian. Dietary requirements including pureed/soft and diabetic desserts are accommodated. Resident dislikes are known, and alternative foods provided, including one customised menu. The chef receives resident dietary profiles and is notified of any changes and any residents with weight loss. Lip plates and specialised cutlery are available as needed. Buffet breakfast is available in one conservatory lounge each morning and those who do not choose a buffet breakfast have breakfast served in rooms. Residents interviewed enjoyed the buffet breakfast dining. Lunch and dinner are self-service. The main meal is at 5.30 pm to 6.00 pm. Meals are kept hot in bain maire dishes placed into a central serving table. Following interviews with the cook, staff and residents/relatives, a previous complaint regarding the food services has been addressed. The food services staff have completed food safety and hygiene training. The food control plan expires 23 January 2019. End-cooked temperatures on main meals and re-heating temperatures are taken and recorded. The chiller, freezer and kitchenette fridges are monitored with daily recordings. All perishable foods in the chiller and kitchenette fridges are dated and covered. The previous finding around fridge temperature recordings and covered and dated food has been addressed. All dry goods in the pantry is dated. Cleaning schedules are maintained. Chemicals are stored safely. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed confirmed satisfaction with the meals provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services	PA Moderate	When a resident's condition alters, a registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits and changes in medications. Discussions with family members are documented in the health summary status notes and identified with a family contact stamp. Not all interventions had been documented to meet the residents needs/supports. Neurological observations following three incidents of unwitnessed falls had been completed. There were three

in order to meet their assessed needs and desired outcomes.		residents on restraint and all monitoring forms had been completed. Monthly weights had been completed in the resident files reviewed. Staff were observed to be assisting residents with meals during the midday and tea meals. This was an improvement on previous audit. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations (including wound size) were in place for six residents with current wounds including one resident (hospital) with a facility acquired stage two pressure injury of the buttock. Short-term care plans were in place for wounds, and the pressure injury was linked to the long-term care plan. There is access to the DHB wound nurse specialist. The service has sufficient pressure injury equipment available and were sighted in use for high risk pressure injury residents. Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for use. Monitoring forms used include (but are not limited to); blood pressure monitoring, behaviour charts, restraint monitoring, blood sugar levels, food and fluid, neurological observations, re-position charts, pain monitoring and monthly weights.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs a recreational officer (DT in training) from Tuesday to Saturday and one recreational officer - RO (orientating on the day of audit), who will work Sunday to Tuesday, with one day where both ROs are on duty. The programme is integrated (rest home/hospital) and recently implemented over the seven-day week. The programme allows for spontaneous activities to occur that reflect resident preference and meet the physical and cognitive abilities of both rest home and hospital residents. There are volunteers involved in activities such as exercises, board games, one-on-one chats, provide music and assisting with group activities. There are a number of lounge areas where activities are held and a large craft room with kitchenette, where crafts and high teas are held. Other activities in the programme include (but are not limited to) a variety of exercises including weekly Tai Chi with a trainer, board games, quizzes, musical entertainment, musical instruments, reminiscing, bowling, outdoor afternoon teas, movies and happy hours with entertainment. There are a number of community visitors to the facility that include school children who join the residents in afternoon and morning teas, canine friends visit three times a week, Reikei therapy volunteer weekly and chaplaincy visits twice a week. There are three church services a week held in the on-site chapel. Themes and events are celebrated. The service has a wheelchair hoist van. Volunteer drivers complete van competency and first aid. There are twice weekly van drives to places of interest and to the community centre for activities. The sunrise club has been commenced for a small group of residents with memory loss. The group meets weekly and a family member assists with the group activities that includes aromatherapy, music, reminiscing and other sensory activities. A men's group was formed to meet the recreational interests of the men. A male volunteer facilitates the weekly group, who meet for discussion and spontaneous activities as desired.

		Each resident has an Eden “tree of life” in their resident file. The activity plan is based on companionship, usefulness, emotion, well-being and communication and is evaluated at the same time as the care plan. The activity assessments and plans reflect individual residents’ hobbies and interests and links with the community. The residents have an opportunity to feedback and provide suggestions on the programme through monthly resident meetings. Meeting minutes and interviews with residents and relatives on the day of audit, evidenced satisfaction with the activities programme. The previous finding round the activities programme has been addressed.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans of permanent residents had been evaluated by a registered nurse within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Short-term care plans reviewed evidenced they had been evaluated and either resolved or added to the long-term care plan if the problem is ongoing. Written evaluations document progress against the resident goals. The resident/relative are involved in the care plan evaluations. The GP reviews the resident at least three monthly. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current building warrant of fitness, which expires 31 March 2019. There is a reactive and planned maintenance programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security	FA	There are call bells in the residents’ rooms and lounge/dining room areas. Residents confined to lounge chairs were observed to have their call bells in close proximity and any residents lying on their beds had the call bell within reach at the time of the audit. The previous finding around resident call bells within reach has now been addressed.

situations.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Longview. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of infections, trends and analysis including microbiology results is completed on the GOSH register. Corrective actions for events above the benchmarking KPIs is reported to the senior management team and clinical meetings. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. At the time of the audit there were three residents with restraints (two T belts and one bedrail) and one resident using an enabler (bedrail). Enablers are voluntary. Assessments, evaluations and consent forms were evidenced in the three resident files reviewed with restraints and one resident using an enabler. Restraint minimisation and enabler use training is included in the in-service training programme.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Moderate	There is a complaints policy to guide practice and this is communicated to residents and family members. A copy of the complaint’s procedure is provided to residents within the information pack at entry. The facility manager leads the investigation and management of complaints (verbal and written). Not all complaint documentation was complete.	Seven complaints (two in 2017 and four in 2018 year to date) have been made since the last audit in August 2017. The complaints reviewed have been acknowledged and investigated, however there is no documented evidence in three of six complaints reviewed that the complainants have been informed or are happy with the complaint outcome/result.	Ensure that all complaint outcomes are communicated to the complainant and that the complainant is happy with the outcome. 60 days
Criterion	PA	There is a complaints policy to guide practice and this is	One of the complaints from 2018	Ensure that all

1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	Moderate	communicated to residents and family members. A copy of the complaint's procedure is provided to residents within the information pack at entry. The facility manager leads the investigation and management of complaints (verbal and written). Not all complaints have been included in the complaint register.	was made through the HDC in March, which was followed up, investigated and closed off, however the complaint had not been documented on the complaint register.	complaints are entered in to the complaint register. 60 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	There is an annual internal audit calendar in place, however not all internal audits for 2018 had been completed as per the required schedule	Eighteen out of thirty-eight internal audits for 2018 year to date, had not been completed as per the annual schedule. Corrective actions were not always documented as completed.	Ensure that the annual internal audit calendar schedule is adhered to 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements	PA Moderate	Internal audits completed were reviewed. Corrective action plans were not consistently documented and implemented where improvements were identified. The October 2017 survey informed an overall satisfaction with the service at Longview Home at 85% for the relatives and 80% for the residents surveyed. Improvements established in areas identified, relating to laundry, food/meals and activities were followed up and completed.	Corrective action plans were not consistently documented and implemented where improvements were identified.	Ensure that any corrective action plans are documented and implemented where improvements are identified. 60 days

is developed and implemented.				
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The recruitment and staff selection process requires that relevant checks are completed. Five staff files reviewed (one clinical coordinator, one RN, two HCAs and one recreation officer) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and orientation checklists. Missing was evidence of up-to-date annual performance appraisals. A corrective action plan has been implemented around addressing the issue of staff appraisals. The service has developed an online appraisal register and that they are working through addressing appraisals.	Five staff files were reviewed; three of the five files did not have documented evidence of an up-to-date annual performance appraisal completed.	Ensure that all staff files include a completed annual performance appraisal. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	In 2018, Longview experienced a significant turnover in RNs. At the same time, there was recruiting issues for suitably qualified and experienced RNs in the Wellington area. Following a recruitment drive over four months, three RNs were employed in August/September 2018 and began their orientation. There were no interRAI training places available until 2019. The PSC general manager in consultation with the DHB portfolio manager, looked at the option of having an interRAI training course for PSC RNs at Longview and other Wellington PSC sites. Five resident files reviewed (three rest home including one respite care and two hospital level) identified an initial assessment and support plan had been completed within 48 hours. One first interRAI assessment for a rest home resident had not been completed within 21 days of admission and the six-monthly routine assessments had not been completed for two hospital residents. Long-term care plans had been evaluated six monthly for the four long-term residents	Routine interRAI assessments had not been completed within the timeframe for two hospital residents and one first interRAI assessment had not been completed for one rest home resident. There have not been enough interRAI trained staff (due to RN turnover) and no training places until 2019. A training course was arranged for PSC RNs at the Wellington head office. All five RNs are now interRAI trained and working to complete all overdue interRAI assessments that occurred during the RN recruitment phase.	Ensure interRAI assessments and reassessments are completed within the required timeframes. 90 days

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Monitoring charts are available to monitor progress towards resident goals where there have been changes to a resident's health. Short-term care plans were sighted in resident files to guide care delivery for residents with changes to health such as infections, behaviours, injury and changes in skin integrity, however not all changes to health and support needs had been documented.	i) Weight on admission had not been completed for one respite care resident. The same resident did not have known pain identified in the short-stay support plan. ii) Interventions for communication as triggered in the interRAI assessment, were not reflected in the care plan for one rest home resident. There was no behaviour chart in place for confusion, as reported in progress notes and GP notes. iii) Another rest home resident who was an insulin dependent diabetic, did not have any signs/symptoms or management for hypo/hyperglycaemia.	Ensure interventions and supports required are documented to meet residents' health needs. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.