

# Northbridge Lifecare Trust - Northbridge Lifecare Trust Rest Home & Hospital

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## 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 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:

<b>Legal entity:</b>	Northbridge Lifecare Trust
<b>Premises audited:</b>	Northbridge Lifecare Trust Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 6 March 2019    End date: 7 March 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	92



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Northbridge Lifecare Trust Rest Home and Hospital (Northbridge Lifecare) provides rest home and hospital level care for up to 96 residents. This includes 16 secure dementia care beds. The service is operated by Northbridge Lifecare Trust and managed by a Lifecare manager and clinical manager who is a registered nurse. The Lifecare manager reports to the director who manages the onsite village facility and reports directly to the board of trustees. Residents and families spoke positively about the care provided.

This surveillance 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, family, management, staff, a contracted allied health provider and a general practitioner. The length of time on-site for this audit was extended owing to the facility being in the process of converting from a paper documentation reporting system to a recently introduced electronic reporting system and the extra time required to access and review the necessary information.

This audit has identified areas requiring improvement relating to inconsistent quality data recording, not all staff appraisals being up to date, overdue interRAI assessments, inconsistent development of long term care plans and incomplete documentation of some residents' forms, such as following a fall, food diaries and bowel charts. Documentation of completed evaluation processes was identified as a corrective action at the previous audit and this remains open.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service demonstrates residents' rights to full and frank information and open disclosure principles are met. Independent interpreter services are available when required.

A complaints register is maintained with complaints resolved promptly and effectively. One Health and Disability Complaint received in 2017 has been closed by the commissioner with the suggested improvement actions being undertaken by the facility.

## 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 low risk.
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Business and quality and risk management plans include the scope, direction, goals and mission statement of the organisation. Monitoring of the services provided to the governing body 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 were 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. Staffing levels and skill mix meet the changing needs of residents.

## 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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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. Residents are seen by the general practitioner within two working days of admission and at least every four or eight weeks thereafter and sooner where clinically indicated. Residents are also reviewed by the physiotherapist and occupational therapist.

An initial nursing care plan is developed on admission. A six monthly multi-disciplinary meeting is scheduled with residents / family to review the resident's care needs and long-term care plan.

The service provides planned activities meeting the needs of the residents as individuals and in group settings.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a five-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## 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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There was a current building warrant of fitness.

## 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. Three enablers and three restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, with data analysed, and trended, and results reported back to staff and management in a timely manner.

## 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	36	0	2	3	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that two internal complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action planning showed any required follow up and improvements have been made where possible. The clinical manager and Lifestyle manager are responsible for complaints management and follow up with input from the quality committee. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>One complaint made to the Health and Disability Commission in June 2017 was closed on 07 February 2019 with no further action to be taken by the commission. However, the complaint was forwarded to HealthCERT for consideration and additional standards were requested to be included in this surveillance audit. The request from the commission to specifically note bowel management, documentation/interventions and reviews for standard 1.3.3, with standards 1.3.4 – assessments and 1.3.5 - planning being added. Standard 1.3.6 (also requested), was reviewed as part of the regular surveillance audit. In response to this request which was received by the provider in February 2019, the service has had an independent review of seven files from each stream of service (hospital, rest home and dementia) undertaken by a contracted quality and risk advisor. Corrective actions were documented following this review which was completed one week prior to this audit. The corrective actions were to be ratified by</p>

		<p>the quality committee at the March meeting. Once this has occurred the implementation of the actions will commence. Findings from this surveillance audit have been raised in criteria 1.3.3.3, 1.3.5.2 and 1.3.8.2 which were also identified in the independent external review undertaken by the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff interviewed understood the principles of open disclosure which are supported by policies and procedures that meet the requirement of the Code. Interpreter services are available and accessible via the DHB if required. Staff knew how to contact the service, in the event this is required. The clinical manager advises occasionally using 'google translate' to communicate with residents. Some staff are able to communicate fluently in other languages to aid communication with residents on day to day care as required. All residents currently in the facility can communicate in English.</p> <p>Family members interviewed stated they were kept well informed about any changes to their relative`s health status and were advised in a timely manner about any incidents or accidents. These communications were documented in the resident`s progress notes and incident records sampled. The family are also contacted about the outcomes of regular and / or any urgent medical reviews.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of trustees showed adequate information to monitor performance is reported including financial performance, incidents and accidents, complaints, infection control, quality data, emerging risks and issues.</p> <p>The care service is managed by a Lifestyle manager who holds relevant qualifications and has been in the role for 30 years. She is supported by the clinical manager who is a registered nurse with a current nursing practising certificate. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The Lifestyle manager reports to the director who manages all village services and is responsible for direct reporting to the board of trustees. He has been in the role for over six years. The Lifestyle manager and clinical manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular attendance at both clinical and management seminars and ongoing educational sessions.</p> <p>The service holds contracts with Waitemata District Health Board (WDHB) for Age Related Residential Care (ARRC) which covers rest home, hospital and dementia care including respite care. All 92 residents were receiving services under the ARRC contract on the days of audit. At the time of audit there were 38 hospital, 38 rest home and 16 dementia care residents receiving care.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, monitoring of outcomes, clinical incidents including infections, wounds and pressure injuries. Monthly quality data report results are reviewed at the quality meeting which is chaired by a contracted quality and risk person. Required quality improvements are allocated to specific nominated staff and time-lined for completion. Each finding is reviewed monthly at the quality meeting related to infection control, health and safety statistics, incidents and accidents, challenging behaviour, falls, complaints and restraint. All data results showed comparative data from previously collected months which identifies any negative trends that needs to be addressed.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, quality team meetings, health and safety meetings and staff meetings. All quality data results are available in the staff communication book and updated monthly. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions. Not all relevant corrective actions are documented on a 'moving on audit action plan' to allow a clear audit process. The clinical manager can verbalise the development of corrective actions and the implementation of actions are identified in related documents reviewed. For the corrective actions that are not clearly documented the evaluation process cannot be identified. However, staff and management can verbalise outcomes.</p> <p>Resident and family satisfaction surveys are completed six weeks following admission. This generally occurs as part of a planned and minuted family meeting. Any concerns are followed up and outcomes are reported back to the resident and their family. This was confirmed during family and resident interviews but was not always documented. The Lifestyle manager confirmed that annual resident and family surveys are also undertaken and followed up. The results of the 2018 survey could not be located at the time of audit owing to the facility being in a state of transition due to the changing of all systems from paper based to computer based.</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 were 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 Lifestyle manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. This was confirmed in the risk register sighted and from meeting minutes of the health and safety committee. Regular audits are undertaken related to the maintenance of a safe work environment with documented follow-up and review of any hazards or issues found.</p>
<p>Standard 1.2.4:</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed</p>

<p>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>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 to management, the board of trustees and to all staff.</p> <p>The Lifestyle manager and clinical manager described essential notification reporting requirements, including for pressure injuries. They advised there had been one notification related to staffing using a section 31 reporting process since the previous audit. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications since the previous audit.</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>	PA Low	<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 (APCs), where required. With the exception of staff annual appraisals, a sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.</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 showed documentation of completed orientation and a six-week post-employment performance review. Performance reviews are then annually but this process is not always completed in a timely manner.</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. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. One registered nurse is rostered one day a week for the sole purpose of undertaking interRAI assessments. (Refer to comments in section 1.3.3.3 related to overdue interRAI). The clinical manager's medication competency was not current.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility 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</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Current staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence for this time. The Lifestyle manager reported that she had completed a section 31 for one duty where a registered nurse could not be found to cover sick leave. (This documentation could not be located on the day of audit but email correspondence with the WDHB portfolio manager confirmed this occurred). This was a one off occurrence and the facility now has a full complement of registered nurses. At the time the section 31 was filed they were short of one registered nurse and the bureau were unable to supply a suitable person.</p> <p>All clinical staff hold a current first aid certificate and there is 24 hour/seven days a week (24//7) RN coverage in the hospital.</p> <p>The kitchen and maintenance staff are managed by the village director.</p> <p>The roster identifies that two dedicated care staff work in the dementia unit across all shifts.</p> <p>The Lifecare manager and clinical manager work Monday to Friday, eight hours per day and are on call. Secretarial duties cover Monday to Friday from 8am to 4.30pm.</p> <p>Household services to cover cleaning and laundry are rostered seven days a week.</p> <p>A contracted physiotherapist works six hours per week and an occupational therapist works five hours per week. Speech language therapy, wound care oversight and some education is conducted by specialist nurses from the WDHB as required.</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>FA</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 based system was observed on the day of audit. Occasionally a paper based medicine record is required to be used and staff could detail how this was communicated. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer or check medicines are competent to perform the function they manage with one exception (refer to 1.2.7.5).</p> <p>Medications are supplied to the facility in a pre-packaged format from a designated pharmacy. An RN checks medications against the prescription before being placed into use. These are checked again at the time of administration. All medications sighted were within current use by dates. Clinical pharmacist input is provided as requested, and as part of the six monthly care / multidisciplinary review. Family members interviewed confirm they are advised of any changes in medications including short course treatments.</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 were within the recommended range. No vaccines are stored on site.</p> <p>Good prescribing practices included the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the medicine chart. Standing orders used, were current and comply with guidelines. There are processes in place to communicate the use of standing orders to the GP. The pharmacists document any cautions or important points to note including if medicines can be crushed.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner should this be required. One resident was self-testing blood glucose levels and informing the staff of the results.</p> <p>Staff are required to report medication errors. These are investigated and responded to in a timely manner.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site. The kitchen manager interviewed has worked in the kitchen for many years. The organisation has an approved food safety plan. This has been audited by the Auckland City Council on 9 August 2018 and an 'A Grade' food rating certificate received. The kitchen service is included in the Village staffing / management structure rather than the rest home and hospital. Buffet breakfasts are now provided to residents in the rest home and dementia unit between 7.30 am and 9 am. A buffet lunch is provided in the rest home between 12.15 and 13.30 am. Staff and residents advise this works well with residents having greater flexibility of meal times and the ability to self-select food choices. Residents can still choose to have their breakfast in their room if they prefer. Staff oversee and assist as required.</p> <p>The five-weekly summer menu was in use. This has been reviewed by a dietitian in February 2019 to ensure it is appropriate for the service setting.</p> <p>All aspects of food preparation, ordering and storage of food complies with legislation. Temperature monitoring of the fridges and freezers is undertaken most days and recorded. A replacement temperature gauge is on order for the walk-in freezer. The ordering of food is the responsibility of the kitchen manager. There is enough food available on site in the event of an emergency.</p> <p>Positive feedback was received from the residents about the food services provided. Residents were seen to be enjoying their lunch. The main meal for the day is served in the evening. Staff were providing assistance to residents as required. Residents were able to enjoy their meal time and were not rushed. Additional food supplies are present in the dementia unit so residents can have easy to eat snacks at any time of the day or night.</p>

		When residents are admitted, the registered nurses discusses the resident's food preferences and/or any special diets which are accommodated as required. Written records detailing individual resident's food allergies, preferences, and dietary needs were present in the kitchen. Special equipment to meet resident's nutritional needs is available. Nutritional supplements and thickeners are available. Dietitian input is sought where required and documented in individual resident's files. This included a resident requiring enteral nutrition.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Long term care plans are not consistently developed within 21 days of admission and are not always sufficiently detailed. This was a previous finding and continues to be an area requiring improvement. Recommendations made by medical staff and allied staff are integrated into the resident's care plan. A manual handling / mobility plan is developed by the physiotherapist for every resident soon after admission. Medical staff and allied staff document a plan of care at the time of each assessment or review.  For residents receiving dementia level of care, individualised activities plans are documented for a 24-hour period. The care plans included triggers and interventions for behaviours.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation in residents' records, shift handover reports, the communication books, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The variances are noted in criteria 1.3.3.3, 1.3.5.2 and 1.3.8.2. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care provided by staff is of a high standard. The health care assistants confirmed that they are informed of changes in the residents' care needs in a timely manner including via shift handover. Residents interviewed advised staff answered call bells in a timely manner. Residents and family members interviewed were satisfied the residents' care needs are being met in a timely manner, and changed where applicable based on the resident's needs. This included on occasions making an informed decision to decline specific investigations, interventions or care.  A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity	FA	The activities programme is provided by six staff including three trained diversional therapists holding the national Certificate in Diversional Therapy. The residents are supported in the rest home 10.15 am to 2 pm or 3.30 pm weekdays, and in the hospital from 10 am to 11.45 am, with some activities (eg, concerts and individual 1:1 activities occurring in the afternoon). A group activity is scheduled for the afternoons in these areas on the weekend. The residents in Sunny Reay (the Dementia unit) are supported with planned activities from 8.30 am to 3.30 pm seven days a week.

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>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 and specific to the residents of all ages. Participation in the activities programme is monitored on a daily basis with activities staff documenting significant events in the residents' records. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan / multi-disciplinary review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents from the rest home, hospital and dementia unit have the opportunity to participate in exercises, outings, movies, games, music and other entertainment. Residents interviewed confirmed participation is voluntary, and they can implement their own social activities / interests if they prefer to do so.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes one to one activities, reminiscence, and distraction. Residents are encouraged to participate in household activities (eg, washing dishes, using the 'dust buster' for cleaning and folding towels) if they want to.</p> <p>A hairdresser is on site weekly. There is a gym and library area that residents can use.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted by the health care assistant (HCA) they advised they are required to report this to the RN on duty and document their concerns in the resident's file. Examples of this communication were noted in sampled residents' files. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress which included the multidisciplinary reviews and any resulting changes.</p> <p>Formal care plan evaluations occur on a six monthly basis, or earlier if indicated. This occurs via a review of the care plan, and the multidisciplinary review / family meeting. InterRAI assessments are not always undertaken prior to care plan review (refer to 1.3.3.3 and 1.3.5.2). Residents have been referred to the needs assessment and coordination service for review of their assessed level of care where applicable. Where progress is different from expected, the service responds by initiating changes to services provided. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds / skin issues, episodes of pain, altered blood glucose levels and challenging behaviours. Evaluations following residents' falls, and completion of bowel monitoring charts and food charts are not consistently completed as required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 18 November 2019) is publicly displayed. All maintenance is overseen by the maintenance manager and his team who are employed by the village. Clear documentation is maintained.</p>



<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</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 a long-term care facility. This includes urinary tract infections, eye, skin/soft tissue infections, respiratory, fungal, multi drug resistant organisms (MDROs) and gastro-intestinal infections. When an infection is identified, a record of this is documented on the infection summary form for the registered nurse responsible for facilitating the infection prevention and control programme. All reported infections are reviewed and included in data once confirmed. Surveillance data is collated monthly, for the rest home / dementia units combined, and the hospital, and analysed to identify any trends, possible aetiology and required actions. Monthly reports are obtained from the laboratory of all positive microbiology cultures. A monthly report is also obtained from the pharmacy of all oral antibiotics provided to residents.</p> <p>The results of the surveillance programme are shared with staff and managers at the monthly staff and management meetings and discussed where applicable at staff shift handovers. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. An infection record is maintained in applicable individual resident's sampled files. The RN responsible for oversight of the infection prevention and control programme is mentoring a new RN in this role. She advises there have been no outbreaks of infections since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, three residents were using bedside rail restraints and two residents were using enablers with one resident having two enablers one a bedside rail and one chair lap belt. Enablers are the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	The service uses a form called the ‘moving on audit action plan’ for corrective actions. This form shows the corrective actions to be taken, by whom and timeline for completion. It is reviewed post implementation and documented evaluation is shown in the quality committee meeting minutes. The quality committee sign off all moving on audit action plans once implementation, outcome and review has been undertaken. However, inconsistent documentation of corrective actions means not all implemented actions can be clearly identified or what outcome was achieved. The corrective actions which are inconsistently documented related to audit findings and issues raised in staff meetings. During interview, staff and management confirmed corrective actions had been implemented as required following satisfaction surveys and audits but that it has not been documented correctly.	Data is not consistently documented to show all corrective actions taken. Required follow up from some resident post six-week admission satisfaction surveys, and some issues	<p>Provide evidence that all corrective action planning is documented on the required form to meet policy and good practice requirements.</p> <p>180 days</p>

implemented.			raised during staff meetings had no documented corrective action plans put in place.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>The service has a robust system to identify, plan and facilitate ongoing education. The education offered covers all aspects of care provision and on-site education is presented by senior staff and visiting guest speakers. Relevant off-site education is offered to staff. Education is documented for each staff member and this process is currently being undertaken both electronically and in hard copy. The Lifestyle manager confirmed that all education will be recorded electronically for ease of staff access and monitoring once their electronic system is fully implemented.</p> <p>Staff annual appraisals are not all up to date. One was last completed in 2016 and two in 2017. The service has a plan in place to update staff appraisals as soon as possible. The clinical manager who oversees staff medication competencies has an expired medication competency which was last undertaken in August 2017. The clinical manager does not undertake medication rounds for residents but she oversees other registered nurses' medication competencies. The clinical manager will get the visiting gerontology nurse specialist from the WDHB to update her competency as soon as possible.</p>	Of the nine files reviewed three had overdue annual staff appraisals. The clinical manager does not hold a current medication competency.	<p>Provide evidence that staff appraisals are up to date and that the clinical manager has a current medication competency</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and</p>	PA Moderate	<p>Prior to acceptance and admission of a resident, the managers encourage the family and resident to visit the facility and information on the facility is provided. At the time of admission, the family and resident are orientated to their room and nearby areas by staff. An initial assessment of the resident is undertaken, and initial care plan developed within 24 hours of an admission. A medical assessment is undertaken within two working days of admission and reviewed as a resident's condition changes, or monthly, unless the resident's condition is documented as stable and suitable for a two-monthly review. All new residents are assessed by a physiotherapist, and occupational therapist who visits the facility once a week and continue to see the resident as required. There is a mobility transfer plan developed for each resident. The initial interRAI assessment follow admission is not consistently conducted within 21 days of admission with an interval of up to 14</p>	The initial interRAI assessment had not been completed within 21 days of admission in three of six applicable residents'	<p>Ensure interRAI assessments are conducted within 21 days of admission and reassessed every six</p>

<p>exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>weeks. Six monthly reviews are also overdue. This does not meet the provider's contract with Waitemata District Health Board (WDHB). Long-term care plans are not consistently developed within three weeks of admission (refer to 1.3.5.2.). At the time of audit, the service had no specific plan in place to address this shortfall. However, staff interviewed advised that the resident's care needs were being communicated via other means including shift handover. The long-term care plans are reported to be based on a range of clinical assessments, including interRAI (if completed), referral information, resident and family input, the NASC (Needs Assessment Coordination Services) assessment, and staff observations / feedback. Some other assessments including falls risk, pressure area risk, and nutritional assessment are completed separately if the interRAI was not completed at the time.</p> <p>Multidisciplinary reviews of all residents occur every six months and included the resident, invited family/EPOA, the GP, activities/diversional therapist, physiotherapist, occupational therapist, and a registered nurse and/or the clinical manager. A formal review of the resident's medication is also completed by the pharmacist with recommendations provided in writing where applicable.</p>	<p>files sampled.</p> <p>Twenty-eight residents are overdue their six monthly interRAI assessment. The six monthly interRAI assessments are overdue by 16 to 209 days.</p>	<p>months or sooner if clinically indicated.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Template forms are used to document the individualised resident's care needs and goals. The long term care plan template includes an area to review and document the resident's needs including but not limited to activities of daily living, personal care, hygiene, mood, behaviour, diet / nutrition, continence management, sexuality / intimacy, cultural /social needs, activities and mobility. The initial long term care plan was not developed within 21 days of admission for three applicable residents' files sampled, or updated in a timely manner when a resident was reassessed as requiring a higher level of care. Long term care plans had been reviewed and / or updated within the last six months for all applicable residents whose files were sampled. However, interRAI assessments are not consistently completed prior to this (refer to 1.3.3.3.). There were some examples of well documented long term care plans that provided clear guidance to staff. However, other long term care plans were more general and included comments about monitoring the resident's bowel function, but did not specifically identify what concerns should be raised with the RN and when, or note the target blood glucose range and what to do if there is a significant variance, for example. For two residents who had frequent falls, whilst staff could detail interventions to minimise the risk of falls, these were not always sufficiently documented or documented in a timely manner (refer to 1.3.3. and 1.3.8.2). Two initial care plans were not dated and one was not signed. Amendments made to the long term care plan are not always dated or signed by the staff member making the changes.</p>	<p>Initial long term care plans are not consistently developed within 21 days. Not all interventions are clearly identified or updated in a timely manner on residents' care plans. Care plans are not always signed and /or dated</p>	<p>Provide evidence that long term care plans are developed within required timeframes and interventions are sufficiently detailed. Ensure care plans are consistently signed and dated when developed or</p>

		<p>The service has had an independent quality adviser undertake a review in February 2019 of 21 residents' care plans and associated documentation. This comprised seven residents in the rest home, hospital and dementia care areas. The findings have been received by the management team, and work is to commence in response to the findings.</p> <p>Short term care plans have been developed in sampled files for new short term issues including infections, wound care, pressure injury or prevention management, and challenging behaviour.</p>	when developed or amended.	amended.  90 days
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Moderate	<p>Two residents' files sampled showed the residents had had an increase in the number of falls. While each event was reported via the incident and accident system, and open disclosure documented, the assessment of the residents following the fall was not consistently documented. There were some examples of comprehensive documentation including monitoring of vital signs and or neurological observation, and short term care plans for any wound care provided. However, there were other examples where the documentation just notes no injury. While nursing staff interviewed advised they assess the resident and monitor a baseline set of vital signs this is not always documented. This included a resident who had fallen twice on the same day. An individualised falls prevention plan was not documented in a timely manner (refer to 1.3.3 and 1.3.5.3) although staff could detail the interventions that had been undertaken. A clock graph diagram is required to be maintained for residents who have more than two falls in the month. This was incomplete for one applicable resident sampled and had not been commenced for another applicable resident.</p> <p>Bowel monitoring charts are maintained for all residents. These are well completed for some residents, although this was not consistent. For other residents, information is not recorded for each day, or notes 'self' which does not sufficiently identify if the resident's bowels have opened or if the resident is independently toileting or the resident has reported their bowels have opened.</p> <p>One resident was commenced on a food chart for three days due to weight loss. The food chart was discontinued after the three days, however information had not been recorded about the resident's intake for three of these meals and any in between meal snacks. The resident was being given a nutritional supplement and more frequent monitoring of the resident's weight was occurring.</p> <p>Monthly (or sooner) checks of residents' weights are documented with infrequent exception. There is a monthly regular review of residents' vital signs.</p>	<p>Bowel charts are not consistently completed. Nursing evaluations following a fall are not always sufficiently documented. Food diaries were inconsistently completed when required.</p>	<p>Ensure all evaluations are sufficiently documented in residents' records.</p> <p>90 days</p>

		Medical and allied staff document their evaluations at each consultation.		
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.