Te Aroha & District Health Services Charitable Trust - Te Aroha & District Community Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Te Aroha & District Health Services Charitable Trust
Premises audited:	Te Aroha & District Community Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 May 2017 End date: 18 May 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 39

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

Te Aroha and District Community Hospital is owned and operated by Te Aroha and Districts Health Services Charitable Trust. The service provides care for up to 43 residents requiring hospital and rest home level care. On the day of the audit, there were 39 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 general practitioner.

The service is overseen by a facility manager (non-clinical), who is qualified and experienced for the role. A clinical nurse manager supports the facility manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has addressed 14 of the 22 shortfalls from the previous certification audit around: cultural safety; informed consent; corrective actions; quality data, adverse event reporting; training, signing and dating documents; admission agreements; clinical supplies; chemical safety; access to call bells; restraint and linen storage.

Improvements continue to be required in relation to: attendance at staff education; service provision timeframes; assessments; care planning; interventions; activities care plan reviews; medication management; and outstanding maintenance.

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.

The policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Te Aroha and District Community Hospital is governed by a Community Trust and is managed by a facility manager and a clinical nurse manager. A 2017 quality and risk management plan is in place. This plan includes the vision, philosophy and values of the organisation. Strategic goals and objectives are documented and are regularly reviewed by the facility manager and the Trust Board. Residents meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. There is a documented education and training programme. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

The facility manager takes primary responsibility for managing entry to the service, with assistance from the clinical nurse manager/registered nurse. Comprehensive service information is available. A registered nurse completes initial assessments, including interRAI assessments. The registered nurses complete care plans and evaluations. Care plans are clearly written and healthcare assistants report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.

A current building warrant of fitness is posted in a visible location (18 September 2017).

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.

Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had no resident using a restraint or an enabler. Staff receive training in restraint minimisation and challenging behaviour management.

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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	19	0	2	5	0	0
Criteria	0	51	0	2	6	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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. Written consents were all signed correctly in the files sampled. Six resident files (three rest home and three hospital -including one long-term chronic and one young person with disability) reviewed demonstrated that advanced directives are signed for separately. The previous audit finding related to consent forms has been met. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint register. Four complaints were received in 2016 and two complaints have been made in 2017 year to date. All complaints reviewed had noted investigation, follow-up timelines, corrective actions when required and resolutions. Discussions with residents and relatives

understood, respected, and upheld.		confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. On the day of the audit there were two residents who identified as Māori. One Māori resident file reviewed had Māori values and beliefs documented. The previous certification audit finding has been addressed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Six residents (two rest home and four hospital) interviewed stated they were welcomed on entry and given time and explanation about the service and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incidents/accident forms were reviewed. The forms include a section to record family notification. All 12 forms indicated family were informed. Four families (three rest home and one hospital) interviewed confirmed they were notified of any changes in their family member's health status. Interpreter services are available through the DHB.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	A Community Trust Board governs Te Aroha and District Community Hospital. The service provides rest home and hospital level care (geriatric and medical) for up to 43 residents. On the day of the audit there were 39 residents including 15 rest home level residents and 24 hospital level residents (including one hospital level resident under the young persons with disability (YPD) contract, two hospital residents under the DHBs primary care inpatient services (PCIS) contract, one hospital resident under the long-term support of chronic conditions (LTSCC) contract and one hospital resident under a carer support contract). All other residents are under the ARC contract. A 2017 quality and risk management plan is in place. This plan includes the vision, philosophy and values of the organisation. Strategic goals and objectives are documented and are regularly reviewed by the facility manager and

consumers.		the Trust Board. The facility manager has been in her role for three years full-time. She has extensive years of experience in managerial roles. A clinical nurse manager, who is an experienced aged care registered nurse (RN) and has been in this role for six months, supports the manager. The facility manager has undertaken a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.
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.	FA	A 2017 quality and risk management programme is in place. Interviews with management and staff reflect their understanding of the quality and risk management systems. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed (every two years). New policies or changes to policy are communicated to staff, evidenced in staff meeting minutes. Adverse event/quality data collected is trended and analysed. This information is discussed with staff at the monthly staff meeting and is available on the staff noticeboard. This aspect of the previous audit finding has been addressed. Internal audits are completed as per the internal audit schedule. Areas of non-compliance include establishing a corrective action plan where opportunities for improvements are identified. Corrective action plans are implemented and are signed off by the person(s) responsible. The previous certification audit finding has been addressed. Health and safety initiatives include a trained health and safety officer (HCA) and a Health and Safety Committee that meets monthly. Hazard reporting is in place and a hazard register is maintained. Recent health and safety initiatives have included inducting all volunteers and external contractors to health and safety. The health and safety officer reports directly to the Board. Two board members sit on the Health and Safety Committee. Falls prevention strategies include an investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Other strategies include sensor mats and half-hourly checks on residents at risk of falling.
Standard 1.2.4: Adverse Event Reporting All adverse,	FA	There is an accidents and incidents reporting policy. The clinical nurse manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at the monthly staff meetings. Twelve incident forms reviewed demonstrated that all appropriate clinical follow up and investigation had occurred following incidents. A RN conducts clinical follow up of residents. Pressure injuries are documented on an

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.		accident/incident form. This aspect of the previous audit finding has been addressed. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Six staff files (one clinical nurse manager, one RN, two healthcare assistants- including the health and safety officer, one diversional therapist and one cook) were reviewed and evidenced that reference checks are completed before employment is offered. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme is being implemented. The in-service training schedule was not fully adhered to and staff attendance at mandatory in-service training is frequently less than 50 %. Since the previous audit, worksheets were introduced to reinforce training and for completion by staff who did not attend. Completion of worksheets has ranged from 80 -100%. Staff have to look up relevant information in order to complete worksheets. Examples of worksheets include Code of Rights 100%, Manual handling= 80%. Cultural awareness and safety 100%.. Healthcare assistants are encouraged to complete an aged care education programme. The nursing staff attend external training provided by the DHB. Staff are appraised annually of their performance.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced	FA	The staffing policy describes staff rationale and skill mix. The facility manager and clinical nurse manager are full-time employees from Monday to Friday. The facility manager is on call for any non-clinical matters. The clinical nurse manager and RN share the on-call duties for any clinical issues. The rest home and hospital units are located in separate buildings. There is one RN on duty in the hospital unit on the AM, PM and night shifts. The clinical nurse manager/RN covers the rest home from 8.00am to 4.30pm and is on call for any clinical issues after hours. She also completes the resident care plans for the rest home. Adequate numbers of healthcare assistants are rostered in the hospital and the rest home. In the hospital unit (25 residents- including one rest home resident), there are three HCA's on the AM shift, two HCA's on the PM shift and one HCA on the night shift.

service providers.		In the rest home (14 residents), there are two HCA's on the AM shift, two HCA's on the PM shift and one HCA on the night shift. Advised that extra staff can be called on for increased resident requirements. Interviews with HCA's, residents and family members identify that staffing is adequate to meet the needs of residents. Activities staff are available five days a week in the rest home and four days a week in the hospital.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All residents' assessments, wound care plans and long-term care plans reviewed were signed and dated by the RN. The previous audit finding has been addressed.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use correctly documents the refund timeframes and the agreements complies with the requirements of the ARRC contract. The previous audit finding related to admission agreements has been met.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner	PA Moderate	Twelve medication charts were reviewed (six rest home and six hospital- including one long-term chronic and one young person with disability). There are policies available for safe medicine management that meet legislative requirements. Six of twelve medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident's medication three-monthly. Allergies were noted and all medication charts had photos. All clinical staff who administer medications have been assessed for competency on an annual basis. Education

that complies with current legislative requirements and safe practice guidelines.		around safe medication administration has been provided. Staff were observed to be safely administering medications. RNs interviewed could describe their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. The standing orders in use comply with the Standing Orders Guidelines 2016. There were three rest home residents self-medicating inhalers on the day of audit, however, not all the required documentation had been completed. The previous finding related to medication management remains. The medication fridge temperature is recorded regularly and these are within acceptable ranges.
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	The service employs a qualified chef and all food is cooked on-site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the chef works closely with the RNs on duty. The kitchen staff have completed food safety training. The chef and cooks follow a rotating seasonal menu, which was reviewed in April 2016 by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. Food is delivered via a bain marie to Laurence House and is plated by the care staff. Food is plated in the kitchen and then served to the hospital residents in the hospital dining room. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	RNs complete a range of assessments on admission to inform the development of the care plan including (but not limited to): interRAI; continence; coombes; Waterlow; and MNA. In the files sampled, not all residents on an ARRC contract had an interRAI re-assessment completed within the required timeframes (link 1.3.3.3). Not all resident files sampled had evidence that the required pain assessments had been completed. In all files sampled, the assessment tools that were documented, were fully completed and signed by a RN. Medical admission assessments were fully documented. Three of six RNs are interRAI trained. The previous finding related to assessment remains.
Standard 1.3.5: Planning	PA Moderate	The long-term care plans reviewed did not describe the support required to meet the resident's goals and needs in all clinical files sampled. There was evidence of involvement of allied health in resident care.

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		The interRAI assessment and other nursing assessments completed were not always used to inform the development of the resident's care plan. Overall short-term care plans were documented for a change in health condition and were signed out or added to the long-term care plan, if the issue was not resolved within 21 days. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Staff interviewed reported they found the long-term care plans easy to follow. The previous audit finding related to care planning remains.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	RNs and HCAs follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RN will initiate a referral (eg, to the district nurse or wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit and staff interviewed reported they had sufficient dressings, medical supplies and equipment to meet the care needs of the residents. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described. The previous audit finding related to medical and dressing supplies has been met. On the day of audit, there were eight wounds and all wound care documentation (assessment, management plans and evaluations) had been fully documented. All wounds have been reviewed in appropriate timeframes. There were three facility acquired pressure injuries. One rest home resident had a stage II pressure injury and two hospital residents- including one YPD, had stage III pressure injuries. The section 31 notifications were completed on the day of audit for all stage III PI's. All PIs had been noted on an accident and incident form. Interviews with RNs and HCAs demonstrated an understanding of the individualised needs of residents. Staff could describe the care required for the resident admitted under the young person with disability contract. There was evidence of pressure injury prevention interventions such as: turning charts; food and fluid charts; regular monitoring of bowels; and regular (monthly or more frequently if required) weight management.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	PA Low	There are two activities coordinators who provide a separate recreational programme for each service level. The recreational programme is provided Monday to Friday in the rest home (Lawrence House) and Monday to Thursday in the hospital. There are a range of activities to meet the recreational preferences and individual abilities including: word games; history; memorabilia; entertainment; craft; exercises; and movies. One-on-one time is spent with residents who choose not to participate in the group programme. Residents in both areas were observed partaking in activities during the audit. Residents and family interviewed confirm participation is voluntary. Residents are encouraged to maintain community involvement and a mobility van is hired for outings and drives.

appropriate to their needs, age, culture, and the setting of the service.		Interdenominational Church services are held monthly. Activities assessments and care plans are documented on admission. Individual activities care plans and goals are developed. A record of individual attendance at activities is documented. Not all residents had the activities care plan reviewed against the identified activities goals or at the same time as the review of the long-term care plan. The previous audit findings related to activities remains. The activity coordinators have a current first aid certificate. Resident meetings provide an opportunity for the residents to provide feedback and suggestions on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	The RNs evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were not all evaluated at least six-monthly or when there was a change in health status. The clinical manager advised there is a corrective action plan in place for the review of all outstanding interRAI assessments and long-term care plan reviews (sighted). Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Three-monthly reviews by the GP were documented. The RN completing the care plan, signs the care plan reviews.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available. The previous audit finding related to the storage of chemicals has been met.
Standard 1.4.2:	PA Low	The building has a current building warrant of fitness that expires on 18 September 2018. The Trust have made

Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		improvements within the home since their last audit which include (but not limited to): the refurbishment of bathrooms in the hospital and the completion of the painting required in resident areas. The receptionist arranges the reactive maintenance with support from the facility manager. Not all reactive maintenance had been completed on the day of audit and there were a number or areas with bare timber exposed around wet areas that require painting. The previous finding related to outstanding maintenance remains. There is an external contractor employed to undertake the scheduled maintenance. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service checks all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff (link 1.2.7.4). Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The previous audit finding related to call bells has been met.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the	FA	Te Aroha and District Community Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Infection control principles were being followed and no linen was being stored in the bathrooms. The previous audit finding related to the storage of linen has been met. A RN is the designated infection control coordinator with support from all staff in the Quality Management Committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.

service.		
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	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. At the time of the audit, the service had no resident using a restraint or an enabler. Staff have completed training on restraint minimisation in July 2016 and challenging behaviour management in October 2016.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint use monitoring forms included documented evidence of restraint use being monitored two-hourly. The previous certification audit finding has been addressed.

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 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	The organisation has a documented policy around the requirements for residents who wish to self-medicate, which includes a consent, assessment and competency review process. Three of three rest home residents who were self-medicating, had not consistently completed the required three-monthly competency assessment reviews.	Three of three rest home residents who were self-medicating, had not completed the three-monthly competency reviews as required by the organisational policy.	Ensure that all residents who are self-medicating complete all required documentation and competency reviews. 30 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a	PA Moderate	The GP charts the medication for all residents and reviews each resident’s medication at least every three months. Where medication was charted for ‘as required’ use, only six resident files sampled had indications for use noted. There were three residents on anticoagulant therapy, who had a variable dose charted orally over	i) Six of twelve medication charts (two rest home and four hospital- including one YPD and one long-term chronic resident) did not have indications for use charted for ‘as required’ medications. ii) Three of three hospital residents on anticoagulation therapy did not have the	i-ii) Ensure all ‘as required’ medications have indications for use charted and all medication is correctly charted and complies with all legal, contractual and

frequency and detail to comply with legislation and guidelines.		a three to seven-day period. The variable anticoagulant therapy dose was charted as a sequential repeating list and did not identify which dose to give on each day and the dose required was not individually signed by the GP.	anticoagulant correctly charted.	professional guidelines. 30 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 Moderate	The RNs complete the assessments and document the care plans. Four of six initial assessments and initial care plans were documented within forty-eight hours of admission and three of six long-term care plans were completed within twenty-one days of admission. One of six residents (hospital) who was admitted in January 2017 had not had a long-term care plan documented till the day of audit (link 1.3.5.2). One of five resident files sampled (hospital) had the interRAI assessment reviewed six-monthly and one hospital resident was not yet due for a review of the interRAI. The service has implemented and is working through a corrective action plan related to interRAI assessments and reviews. Thirteen interRAI assessments have been updated since the project was implemented in January 2017.	i)Two of six resident files sampled (one rest home and one hospital), did not have the initial assessment or initial care plan completed within the required timeframes. ii)Three of six resident files sampled (one rest home and two hospital) did not have the long-term care plan documented within twenty-one days of admission. iii) Four of five files (three rest home and one hospital) had an interRAI assessment review completed, but not in the required timeframes. iv) In three of the ARC files reviewed, (two rest home and one hospital) the interRAI reassessment was completed after the review of the long-term care plan.	(i-iii) Ensure that all initial assessments, initial care plans, long-term care plans and interRAI assessments and reviews are completed in the required timeframes. (iv) Ensure that all InterRAI assessments are completed before the LTCPs are developed so that they inform the care plans 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are	PA Moderate	The RNs interviewed stated that the RNs are responsible for completing the initial assessments (including interRAI) and any other assessments required for a change in health condition. Not all residents reporting pain in the progress notes or medical notes	Four of four resident files reviewed (two rest home and two hospital- including the tracer) with pain, as noted in the progress notes and medical notes, did not have ongoing pain assessments documented.	Ensure that all residents reporting pain have a pain assessment documented.

identified via the assessment process and are documented to serve as the basis for service delivery planning.		had pain assessments completed.		60 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	The RNs are responsible for the documentation and review of all care plans. The registered nurses complete the interRAI and other assessments. The interRAI assessment outcomes were not used to inform the development of the care plan as they were often completed after the care plan review (link 1.3.3.3). One hospital resident admitted in January was not yet due for a review. One hospital resident admitted in January 2017 had an interRAI assessment completed in April 2017 (link 1.3.3.3). The resident did not have any care plan documentation in the clinical file. The registered nurse working on the documentation of the first long-term care plan had removed the initial care plan from the resident's clinical file. The long-term care plan was completed during the audit and placed in the resident's file. The long-term care plans reviewed did not describe the support required to meet the resident's goals and needs in all clinical files sampled. The care plan also provides guidance on the equipment to be used. The pressure relieving equipment in use for two residents with pressure injuries was not documented in the resident's care plans	i) One hospital resident admitted in January did not have a long-term care plan completed till the day of audit. ii) In five of six files reviewed (three rest home and two hospital-including one resident admitted under the long term chronic and one resident admitted under a young person with disability), the care plan interventions did not fully guide staff in the management of: risk of aspiration; management of seizures; care requirements for quadriplegia; suprapubic catheter; indwelling catheter; increasing pressure injury risk; diabetic emergency management plan; prevention and management of chronic UTIs; high falls risk; verbal aggression; tinnitus; chronic anaemia; and history of weight loss. iii) Two of two hospital residents (including the hospital tracer) using pressure relieving devices did not have the equipment in use noted in the care plan	i) Ensure that all residents have a long-term care plan documented. ii) Ensure care plan interventions are documented for all assessed care needs and documented in sufficient detail to guide the care staff. iii) Ensure that all equipment in use is documented in the care plan 60 days

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	The activities coordinators complete an activities assessment on admission and document activity care plans in consultation with the resident or their family. The separate rest home and hospital group activity programmes are planned a month in advance and are on display on noticeboards in each area. In the files sampled, the activity care plans that were required to be reviewed had been reviewed, but not at the same time as the review of the long-term care plan. The activity care plans were not reviewed against the resident's stated goals.	Four of four activity care plans due for review (two rest home and two hospital- including the tracer) did not have the activity care plan reviewed at the same time as the review of the long-term care plan and the activity plan was not reviewed against the identified resident goals.	Ensure that the activity care plans is reviewed at the same time as the review of the long-term care plan and reviewed against the identified resident goals. 90 days
Criterion 1.3.8.2 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.	PA Moderate	The RNs interviewed advised they undertake a review of the long-term care plan at least six-monthly. However, in the files sampled, only two of five care plans due for review had been reviewed six-monthly. There was evidence in the medical notes that the GP assesses the resident with an acute change in health condition.	Three of five (two rest home and one hospital) long-term care plans due for review, had been reviewed six-monthly. This previous finding remains open.	Ensure that the long-term care plan is reviewed at least six-monthly. 90 days
Criterion 1.4.2.4 The physical environment minimises risk of	PA Low	Both buildings have sufficient space for residents to mobilise using mobility aids. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. A maintenance schedule is	Not all required maintenance had been completed or scheduled on the day of audit.	Ensure that all reactive maintenance is completed.

harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.		documented, however, not all required maintenance was on the schedule or had been completed. There were areas of exposed timber behind the hand basins in Laurence House, in the laundry and by the dish wash area in the kitchen, that were not documented on the maintenance schedule.		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.