

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 and 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: 14 November 2019 End date: 14 November 2019
Proposed changes to current services (if any):	Nil
Total beds occupied across all premises included in the audit on the first day of the audit:	44



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Te Aroha and District Community Hospital is governed by a community trust board. The service provides rest home and hospital level care (geriatric and medical) for up to 44 residents. On the day of the audit there were 44 residents. The residents, relatives and general practitioner interviewed commented positively on the care and services provided at Te Aroha.

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 a review of policies and procedures; a review of residents and staff files; observations; and interviews with residents, family, management, staff and a general practitioner.

The clinical facility manager is supported by a nurse lead who provides oversight of clinical care.

Four of the five previous audit shortfalls have been addressed. These are related to; internal audits, corrective actions, medication documentation; and restraint monitoring. Improvements continue to be required around care plan interventions.

The audit identified further improvements required around; complaints register; documentation of analysis of clinical data; dispensation for a resident requiring hospital level of care; neurological observations; timeframes for completion of documentation; and registered nurse follow up.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Family members stated that they are informed of any change of care or incident related to their family member when this occurs.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a clinical facility manager and nurse lead who provide operational management and clinical management for the service.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the nurse lead and/or clinical facility manager. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme is implemented.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An annual staff education and training plan is well attended with all staff attending mandatory training as required. Registered nursing cover is provided on all shifts in the hospital building at all times.

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 registered nurses are responsible for each stage of service provision. A registered nurse completes initial assessments, risk assessments, interRAI assessments and long-term care plans within the required timeframes. Care plans are evaluated at least six monthly and meet the resident's current needs and supports.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three monthly.

A diversional therapist oversees the activity team and coordinates the activity programme for the rest home and hospital. The programme includes community visitors and outings, entertainment and activities that meet the individual and group preferences and abilities for each resident group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current 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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. There are no residents with restraint and four residents with an enabler. Restraint management processes are in place.

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.

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit. An external provider completes quarterly benchmarking reports with these used to review trends.

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	13	0	2	3	0	0
Criteria	0	39	0	4	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>	PA Low	<p>There is a documented complaints policy and complaint forms are freely available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. There is a template identified as the complaints' register.</p> <p>There has been one complaint from the Health and Disability Commission that was received by the organisation in April 2019. This is still being investigated by the Commission and the organisation.</p> <p>There has been one internal complaint in 2019 which has been fully investigated. The complainant was informed within timeframes documented in policy with evidence of resolution of the complaint confirmed.</p> <p>All staff interviewed were able to describe the process around reporting complaints.</p> <p>One family member stated that they had made a complaint the day before the audit and felt that this had been resolved promptly and to their satisfaction. Other family members and residents interviewed stated that they had no reason to complain.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services 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</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>and frank open disclosure occurs. Fifteen incident/accidents forms reviewed had documented evidence of family notification or noted if family did not wish to be informed.</p> <p>Relatives interviewed (four hospital) confirmed that they are notified of any changes in their family member's health status. A residents'/relatives meeting occurs monthly. Any issues raised from these meetings are followed up by the facility manager. Interpreter services are available as required. Residents interviewed (three rest home and three hospital) confirmed that communication was good.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>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 44 residents. On the day of the audit, there were 44 residents. There were 18 rest home level residents (14 in the rest home known as Lawrence House and four residents requiring rest home level of care in the hospital building) including one respite resident; 22 residents identified as requiring hospital level of care (one under the post-acute convalescing care contract (PACC) contract, one YPD and two under a palliative care contract and four under a general practice primary care admission contract). All other residents were under the age-related residential care services agreement.</p> <p>There is a strategic plan for three years dated 11 November 2018. This includes the mission, vision, core values and key strategic objectives. These are reviewed by the clinical facility manager and by the board.</p> <p>A 2019 – 2020 risk management plan is in place. This includes documentation of key risks and strategies to mitigate risks. The risk plan is reviewed by the clinical facility manager who escalates any issues to the board.</p> <p>The clinical facility manager (RN) has been in the role for three years and was clinical manager for the service prior to this role. They have extensive experience in managerial roles prior to working at Te Aroha. The clinical 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 and is supported in her role by a clinical operations administrator (enrolled nurse) and nurse lead.</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</p>	<p>PA Moderate</p>	<p>There is a business quality plan that includes quality goals and risk management plans for Te Aroha. The clinical facility manager and nurse lead are responsible for providing oversight of the quality programme on-site with the enrolled nurse providing practice support (eg, for completion of audits). A monthly report is provided to the board, including both business and clinical quality data. Interviews with staff and a review of meeting minutes confirmed that there is discussion about quality data at various staff meetings.</p> <p>There is a well implemented document control system with policies and procedures reviewed as per policy. Staff stated that they have access to policies.</p> <p>There is a quality and risk management programme in place. Data is collected in relation to a variety of quality</p>

improvement principles.		<p>activities. The internal audit schedule is implemented with evidence that corrective action plans and resolution of issues is documented. The corrective actions related to implementation of the internal audit schedule has been addressed. This is an improvement on the previous audit. Clinical data is tabled at various staff meetings including the registered nurse and staff meetings. Staff and managers stated that there is discussion of the clinical data, however this discussion is not documented.</p> <p>There has last been a satisfaction survey in May 2019 with one returned questionnaire. There is a satisfaction survey for residents receiving short-term care (eg, under the primary care contract, PACC or respite care). There are a large number of responses to this survey, however the survey results are not collated and there is no evidence that this has been discussed with residents.</p> <p>The organisation has a rich source of data particularly clinical data with this tabled at the registered nurse meeting. There is a minimal documentation of analysis of clinical data.</p> <p>The clinical facility manager and nurse lead describe how they are working to improve the service with refurbishments made to bedrooms. Interviews with staff confirmed that there is discussion about quality data at various staff meetings.</p> <p>The service has a health and safety management system that is regularly reviewed. The health and safety meeting includes review of any incidents or hazards. Hazard identification forms are completed when a hazard is identified and those reviewed for 2019 showed that any issues are resolved immediately. Restraint and enabler use (when used) is reported within the management and registered nurse meetings. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Health and safety is discussed at the health and safety meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>There is an accidents and incidents reporting policy. The clinical facility manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents with all incident forms signed off by the nurse lead and/or the clinical facility manager.</p> <p>Fifteen incident forms reviewed demonstrated that appropriate clinical follow-up and investigation has occurred following incidents. Discussions with the staff confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The policy around management of incidents states that neurological observations are to be taken when there is a head injury following a fall or there is an unwitnessed fall. Neurological observations were not documented when this occurs in the sample of relevant incidents reviewed during the audit.</p> <p>The nurse lead and the clinical facility manager could describe reporting of serious events but were not aware of the need to seek approval to place a resident requiring hospital level care into a rest home bed.</p>

		Dispensation has not been received for the resident in the rest home bed who requires hospital level of care.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications and experience. A copy of practising certificates is kept. Eight staff files reviewed (the clinical facility manager, two registered nurses, three healthcare assistants, one activities assistant and one nurse lead), identified that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. Completed orientations were on file and staff interviewed described the orientation programme provided. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the healthcare assistants and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are seven RNs, five have completed interRAI training and two are in the process of completing. All staff have a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There are policies in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager (RN) is on duty Monday to Friday and is available on call weekends and after hours. The clinical operations administrator is on duty Monday to Friday. There is a RN on duty 24-hours a day with additional hours provided for interRAI and care planning.</p> <p>The healthcare assistant (HCA) rosters are as follows;</p> <p>For the rest home wing (14 rest home residents and one hospital), there is one long shift and one short shift for the AM and for the PM and one HCA at night.</p> <p>For the hospital wing (21 hospital, 4 rest home residents and 4 under the GP contract), there are two long shifts and two short shifts for the AM, there are two long shifts and one short shift for the PM and one HCA on nights.</p> <p>Residents and relatives stated at times they felt there was not enough staff on duty at all times. Advised that since the audit the service has added an extra shift in the rest home on a Saturday. Staff stated they feel supported by the RN, and facility manager who responds quickly to after-hour calls. Rosters reviewed evidenced staff were replaced when sick and call bell response times are being met</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses and medication competent healthcare assistants who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Standing orders were current and reviewed annually by the general practitioner. There were no residents self-medicating on the day of audit.</p> <p>All medications are stored safely. All eye drops were dated on opening. The medication fridge is monitored daily. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>The facility uses an electronic medication system. All 10 medication charts reviewed (six hospital, four rest home) had photo identification and allergy status recorded. The GP has reviewed the medication charts three monthly. Indications for use for documented for prn medication. Reconciliation of medication was completed on admission. The service has effectively addressed the previous certification findings around medication management.</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>All meals at Te Aroha are prepared and cooked on site. The service has two cooks who work 5.30 am to 2.00 pm and a weekend relief cook. There are two kitchenhands who work from 6.30 am to 2.00 pm and 4.00 pm to 7.00 pm. All kitchen staff have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen.</p> <p>Meals are transported to the rest home and hospital dining rooms in bain maries. The service provides a room meal service for those residents that prefer having their meals in their rooms. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. Staff were observed assisting residents with their meals and drinks in the hospital and rest home dining room. Evening meals are reheated by the kitchenhands. The kitchen team provides a community meals on wheels service and daily lunch for the residents attending the day club.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked daily, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements, cultural and religious preferences and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Four long-term care resident care plans were reviewed. All four long-term care plans reviewed recorded the resident's problem/need and objectives, however not all care plans had sufficient interventions that reflected the residents' current needs and goals. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as referral to dietician, podiatrist and physiotherapist. Residents and their family/whānau that are involved in the care planning and review process have evidence documented in the family contact form. Short-term care plans reviewed were in use for changes in health status. Staff interviewed reported they found the plans easy to follow. The service continues to have findings around care plan interventions</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are identified with entries in the family contact form and documented in the resident progress notes.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessment forms, wound evaluations and comments were in place for six hospital residents with wounds (four chronic leg ulcers and two skin lesions) and three rest home residents (two chronic leg ulcers and one skin tear). There were two hospital level residents with pressure injuries (facility acquired stage one and stage two) on the day of audit. There was a range of equipment readily available to minimise pressure injuries.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain charts, behaviour chart, continence, daily skin checks and two hourly positioning.</p> <p>ne rest home resident that had an unwitnessed fall did not have neurological observations completed post fall (link 1.2.4.3).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>There is an activity team which consists of a diversional therapist that works from Monday to Friday in the hospital and an activities coordinator in the rest home (working Monday to Friday). The healthcare assistants manage the activities programme over weekends and public holidays. There are volunteers that facilitate the darts programme, play the piano and arrange the twice a week (Monday and Thursday) residents morning tea. The team have current first aid certificates.</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>The rest home and hospital have separate activity programmes and some integrated group activities such as entertainment, Friday happy hour and outings. There is a variety of activities that meets the abilities of all residents and to meet the physical, intellectual, sensory and social needs of the residents. Individual one-on-one time is spent with residents who choose not to join in group activities or are unable to participate in activities.</p> <p>Residents are supported to attend the weekly interdenominational church services held in the facility and Catholic and Anglican Church members come in to give communion. There are regular entertainers visiting the facility. Residents are encouraged to maintain links with the community and include inter-home visits, local RSA and other visits into the community. The residents have regular van outings in the summertime. Special events and festivities like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated, and families are invited to attend.</p> <p>An activities assessment is completed soon after admission in consultation with the resident/family and reviewed at least six monthly with the care plan. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. Residents and relatives interviewed voiced satisfaction around the activities programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission (link 1.3.3.3). The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status (link 1.3.3.3). The GP reviews the residents at least three monthly or earlier if required. Ongoing registered nurse evaluations occur for all hospital level residents and are documented within the progress notes, however there was a shortfall noted in all rest home resident files (link 1.3.3.4). Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents, and these are also evaluated six monthly. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 8 September 2020. Healthcare assistants interviewed stated they have adequate equipment to safely deliver cares for rest home and hospital level of care residents.</p> <p>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 documented and implemented with rooms in the process of being refurbished. Reactive maintenance occurs in a timely manner.</p> <p>All medical and electrical equipment is serviced and/or calibrated annually. Hot water temperatures are</p>

		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 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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at staff and clinical registered nurse meetings. An external agency provides benchmarking. Meeting minutes including graphs are available to staff. Trends are identified and staff stated that there is discussion around the data with preventative measures put in place (link 1.2.3.6). A monthly report is forwarded to the trust board meeting. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There is no use of restraint in the service and two residents using an enabler (bed loops). Both are in the rest home and both are identified on the register. Staff education on restraint minimisation and management of challenging behaviour has been provided in 2019.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. Staff confirmed that restraint is only used as a last resort. As per the restraint minimisation policy, staff including the nurse lead, stated that all restraints will be monitored a minimum of two-hourly. Training was provided to all staff in June 2019 and the training included requirements for monitoring of any restraint while in place. The training included a test which required staff to document on a restraint monitoring chart. The corrective action identified at the previous audit 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)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	There is a complaints register available to document the complaints. This has not been maintained.	Written complaints (and potentially verbal complaints) are not documented on the complaints register.	<p>Complete a register of complaints that includes all complaints, dates, and actions taken.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement</p>	PA Moderate	The organisation collects clinical data from a variety of sources. This includes tabling of data at the registered nurse meetings with staff and managers stating that they discuss weights, falls, tube management, infection control, hazards and health and	(i). There is a minimal documentation	(i). Document evidence of analysis of

<p>data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>safety, medication incidents, documentation, use of restraint and enablers, audits, education, etc. The service is also part of an external benchmarking programme that compares clinical data from other rest homes and hospitals. The data is tabled at the registered nurse meeting showing any variation from the norm or expected parameters. The clinical facility manager, nurse lead and staff stated that there is extensive discussion of the data, however this is not documented.</p> <p>There has last been a satisfaction survey in May 2019 with one returned questionnaire. There is a satisfaction survey for residents receiving short-term care (eg, under the primary care contract, PACC or respite care). There are a large number of responses to this survey, however the survey results are not collated and there is no evidence that this has been discussed with residents and families. The previous improvement required at the previous audit has not yet been addressed.</p> <p>There is an internal audit schedule that is implemented apart from the satisfaction survey which is to be completed annually. Action plans have been documented for all internal audits where a shortfall has been identified and the recommendation identified at the previous audit (1.2.3.8) has been addressed</p>	<p>of analysis of clinical data with evidence of improvements to service delivery as a result of the discussion.</p> <p>(ii). A satisfaction survey for residents and families in the hospital and rest home has not been completed adequately to determine levels of satisfaction with the service</p>	<p>data with corrective action planning and documentation of resolution of issues.</p> <p>(ii). Complete a satisfaction survey, collate results and ensure that residents and families are informed of the results</p> <p>90 days</p>
<p>Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification</p>	<p>PA Low</p>	<p>Lawrence House is a designated stand-alone building with 15 beds for rest home residents. Currently there are 14 residents who require rest home level of care and one resident who requires hospital level of care. The clinical facility manager has not applied for dispensation for the resident requiring hospital level of care. Staff stated that the resident initially came into the hospital building as hospital level of care, but the resident and family asked to be transferred to the Lawrence House. Staff also stated that the resident had improved over time and, for example, no longer required use of a wheelchair and had become more independent. The nurse lead showed documentation on the day of audit to indicate that the resident was on the list for a review by the needs assessment service to identify if they still required hospital level of care or could be cared for as rest home level of care. Lawrence House is staffed by one healthcare assistant on each shift. They have access to other staff or a registered</p>	<p>One resident identified as requiring hospital level of care is being cared for in a dedicated rest home building. The service has not obtained a</p>	<p>Ensure a dispensation from HealthCERT is obtained for the resident requiring hospital level of care in a rest home environment.</p>

reporting and the correct authority is notified where required.		nurse by phone or through the call bell system.	dispensation from HealthCERT.	30 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incident forms are documented with evidence of family being informed. All are signed off by the clinical facility manager and/or the nurse lead. One of five residents who had a fall was not required to have neurological observations taken. The other four who had an unwitnessed fall did not have these taken.	Four of four residents who had an unwitnessed fall in October or November 2019 did not have neurological observations taken.	Ensure that neurological observations are taken when there is a head injury following a fall or there is an unwitnessed fall. 90 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	PA Low	Registered nurses (RNs) are responsible for the resident's assessments and the development of nursing care plans. The review of the resident's files reflected that not all documentation was completed within expected timeframes.	(i) One hospital and one rest home resident did not have an interRAI assessment and long-term care plan completed within 21 days of admission. (ii) Two hospital and	(i) Ensure an interRAI assessment and long-term care plan is completed within 21 days of admission. (ii) Ensure routine six-monthly interRAI assessments and long-term

consumer.			two rest home residents did not have routine six monthly interRAI assessments and long-term care plans evaluations were not completed on time.	care plan evaluations are completed on all long-term residents. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Long-term care plans are evaluated six-monthly or when a resident's condition changes. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Healthcare assistants document in all the residents progress notes daily. Ongoing registered nurse evaluations occur for all hospital level residents and are documented within the progress notes daily, however there was a shortfall noted in all rest home resident progress notes; there was no regularly documented registered nurse input in the progress notes	Rest home residents did not have regular registered nurse evaluations and input documented in the progress notes.	Ensure that the rest home residents have regularly documented registered nurse evaluations and input in the progress notes. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the	PA Moderate	Interviews with the clinical lead and registered nurses demonstrated an understanding of the assessment, monitoring and management plans. Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, food and fluid intake. Short-term care plans sighted on the day of audit included wounds, infections and skin tears, however there were insufficient documented interventions in place for residents identified with weight loss, challenging behaviours and a history of recurrent urinary tract infections. The previous shortfall	(i) Two rest home residents with identified weight loss did not have sufficient interventions	(i) Ensure interventions are in place for residents with identified weight loss. (ii) Ensure

<p>desired outcomes identified by the ongoing assessment process.</p>		<p>around interventions continue to be an area requiring improvement.</p>	<p>in place in the care plan.</p> <p>(ii) One rest home resident with an history of recurrent urinary tract infections did not have documented measures in place to reduce the risk of infection.</p> <p>(iii) One rest home resident with challenging behaviours did not have interventions in place identifying triggers of challenging behaviours, management strategies and behaviour monitoring charts</p>	<p>interventions in place for identifying urinary tract infections and minimising risk for residents that have recurrent urinary tract infections.</p> <p>(iii) Ensure residents with challenging behaviours have a behaviour plan in place that includes triggers, strategies to de-escalate and behaviour monitoring charts.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.