# Presbyterian Support Southland - Resthaven Village

## 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 BSI Group New Zealand Ltd, 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Southland

**Premises audited:** Resthaven Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 7 December 2020 End date: 8 December 2020

**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:** 59

# 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** |
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|  | 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 |
|  | 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

Resthaven is part of the Presbyterian Support Southland (PSS) organisation and provides care for up to 60 residents across three service levels (rest home, hospital [medical and geriatric], and dementia care). On the day of audit, there were 59 residents in total.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the nurse practitioner, and management. Residents and relatives interviewed were very complimentary of the services and care they receive.

The facility manager has been in the role since May 2019 and is a registered nurse. She is supported by an experienced clinical manager who has been in the role for eight years. They are supported by the quality manager, registered nurses, and a team of experienced staff.

This audit has identified shortfalls around discussions in meetings and monitoring charts.

## Consumer rights

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| 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. |

A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## Organisational management

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

PSS Resthaven have implemented the 2020 quality plan which includes benchmarking. Quality improvement initiatives are developed, implemented and discussed at relevant meetings. Meetings are held to discuss quality and risk management processes. Residents’ meetings have been 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.

An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed.

There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents, relatives and staff report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

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| 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 low risk. |

Registered nurses are responsible for care plan documentation. InterRAI assessments and care plans are completed and reviewed within required timeframes.

The activity team provide an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The activity programmes meet the abilities and recreational needs of the groups of residents.

The service uses an electronic medication management system.

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

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| 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. |

PSS Resthaven has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. There are sufficient communal areas within the rest home, hospital, and dementia areas that include lounge and dining areas, and smaller seating areas. External garden areas are easily accessible for residents using mobility aids with suitable pathways, seating and shade provided. The external areas in the dementia units are secure and provide areas of interest.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy that includes the provision of a restraint-free environment. A register is maintained for all residents with enablers and with restraint. There were two residents documented as using restraint and no residents with an enabler. Staff are trained in restraint minimisation.

## Infection prevention and control

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| 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. The newly appointed manager is the designated infection control nurse with support from the quality team and head office. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly.

Covid 19 was well managed, logs were maintained of staff and resident temperature checks. Adequate supplies of personal protective equipment were sighted. The outbreak in 2019 was well managed and reported appropriately.

## Summary of attainment

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

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| **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 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. Fifteen complaints have been received since the last audit, ten care related complaints in 2019, and five complaints in 2020 including one complaint with the Health and Disability Commissioner, which remains open. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Registered nurses and care workers interviewed confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes. Residents and relatives advised that they are aware of the complaints procedure and how to access forms and feel comfortable discussing concerns with management.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Comprehensive information is provided at entry to residents and family/whānau. Three residents interviewed (two rest home, one hospital) stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the facility manager and clinical manager are available to residents and relatives and they promote an open-door policy. Incident forms reviewed for November 2020 evidenced that relatives had been notified on all occasions. Two relatives interviewed (one hospital and one dementia) advised that they are notified of incidents and when residents’ health status changes promptly. The clinical staff interviewed (the nurse practitioner, four registered nurses, five care workers, one physio aid/ health and safety representative/care worker and the activities coordinator interviewed fluently describe instances where relatives would be notified.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Resthaven is one of four aged care facilities under Enliven Residential Services for Older People (SOP), a division of Presbyterian Support Southland (PSS). Resthaven is certified to provide rest home, hospital (medical and geriatric), and dementia care. On the day of the audit there were a total of 59 residents: 20 rest home (including one resident on an Accessibility Ministry of Health contract), 30 hospital level care (including one resident on an Accessibility Ministry of Health contract, and one resident on an exceptional circumstance contract), and nine dementia level care.The facility manager at Resthaven is a registered nurse and has been in her role since May 2019 and has previous business management experience. The clinical manager is an experienced registered nurse and has been in her role for eight years. They are supported by the quality manager (present on the days of the audit).Presbyterian Support Southland have employed a nurse practitioner who has direct and regular access to general practitioners. Presbyterian Support Southland group have developed a charter that sets out its vision and values. Resthaven have identified a vision, values and goals across all departments. The quality plan for 2020 - 2021 documents each goal with initiatives and key performance targets to be implemented. The facility manager is responsible for the implementation of the quality programme at Resthaven. The facility manager has completed more than the required eight hours training including an online leadership training session and attends the district health board (DHB) age residential care meetings, and monthly management meetings.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Presbyterian Support Southland has an organisational business/strategic plan that includes quality goals and risk management plans for Resthaven. The quality and risk management programme is designed to monitor contractual and standards compliance. Monthly data is collated from the electronic system and benchmarked between other Presbyterian support organisations. An internal audit schedule is being implemented. Areas of non-compliance identified through quality activities are actioned for improvement. The staff report quality data including corrective action plans are discussed at meetings held, however this is not reflected in the meeting minutes. Regular meetings are held including: quality (including infection control and health and safety), staff, clinical meetings, and three-monthly resident meetings.Annual satisfaction surveys are held. The 2019 resident and relative satisfaction surveys could not be located at the time of the audit, however the 2020 survey evidenced overall satisfaction with the service provided, especially around food services, activities, communication and feeling part of the decision-making processes. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.Falls prevention strategies are implemented for individual residents on a case-by-case basis.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event. Ten incident forms reviewed identified registered nurse follow up. Incident/accident forms include a section to record relatives have been notified. All incident reports reviewed evidenced relatives had been notified. Neurological observations had been completed for all unwitnessed falls and where there was potential for head injury. Opportunities to minimise the risk of future incidents (where appropriate) were identified. The care workers interviewed could discuss the incident reporting process. Discussions with both the facility and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been six Section 31 notifications made in 2019 and one on 2020 since the previous audit (an externally acquired stage 3 pressure injury, one staff injury, the boiler was not emptied and posed a fire risk, an intruder, one trespass order and the evacuation of the facility due to floods in February 2020). The public health team were notified of the outbreak in 2019.  |
| 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 resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (one clinical manager, one registered nurse, one enrolled nurse, one diversional therapist and two care workers). All had relevant documentation relating to employment, and current appraisals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. There is evidence in the registered nurse files of attendance at the DHB external training. Interviews with care workers confirm participation in the New Zealand Qualification Authority through the Careerforce programme. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. Currently there are five care workers with level 4 NZQA, 13 care workers with level 3 NZQA. A total of 36 staff including the two activities coordinators have completed the four dementia standards, this includes all the staff who work in the dementia unit plus staff from other areas in the service.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a total of 76 staff. Resthaven has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Rosters reviewed evidenced that staff were replaced when sick. The facility manager works five days a week (Monday to Friday) and is supported by the clinical manager who works Monday to Friday. There is registered nurse cover across all shifts in the hospital wing. A registered nurse or enrolled nurse or a team leader (senior care worker with a current medication competency) works in the morning and afternoon shifts in the rest home area and there is a team leader across all shifts in the dementia unit. All registered nurses, the enrolled nurse and team leaders have current first aid certificates. Waimea wing (hospital) 29 beds (27 hospital level residents and two rest home level). The registered nurse works from 6.45am to 3.15 pm. The RN is supported by five care workers rostered on the morning shift: 4x 7am to 3pm and 1x 7am to 11am. The afternoon shift has: a registered nurse 2.45pm to 11.15pm and five care workers; 4x 3pm to 11pm and 1x 4.30pm to 8.30pm. There is one registered nurse and one care worker overnight from 11pm to 7am.Charlton wing (rest home) 21 beds (five hospital level residents and 16 rest home).The registered nurse/ enrolled nurse or team leader works from 6.45am to 3.15pm. The RN is supported by: two care workers rostered on the morning shift: 1x 7am to 3pm and 1x 7am to 1.30pm. The afternoon has: a registered nurse/ enrolled nurse or team leader from 2.45 to 11.15pm. They are supported by: two care workers rostered; 1x 3pm to 11pm, and 1x 4.30pm to 8.30pm. One care worker is rostered overnight from 11pm to 7am (medication competent). Oban wing (dementia) has 10 beds, nine residents.There is one team leader (medication competent) from 6.45am to 3.15pm and one care worker from 7am to 3pm. The afternoon shift has one team leader from 2.45pm to 11.15pm, and one care worker from 3pm to 11pm. One medication competent care worker is rostered overnight. Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation is completed by two RNs on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored. The medication fridge temperatures are recorded weekly and these are within acceptable ranges. Medication room temperatures are recorded and remain below the recommended 25 degrees Celsius. Resthaven uses an electronic medication management system. All nurses and care workers who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and care workers interviewed could describe their role regarding medicine administration. Standing orders are not used. There were no residents self-medicating residents at the time of audit. The service uses four weekly blister packs for regular and ‘as required’ (PRN) medications. Ten electronic medication charts were reviewed. All medication charts have photograph identification, allergies and three-month GP reviews documented. Indications for use has been documented for all ‘as required’ medications.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a large commercial kitchen, and all meals are cooked on-site for the entire facility. All staff working in the kitchen have food safety certificates. Food is served from the kitchen to the adjacent dining area and transported in a bain-marie to the dementia unit. A current food control plan is in place expiring on 19 December 2021. Fridges, and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridges was covered and dated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. The menu is a four-weekly seasonal menu, which was designed and reviewed by a registered dietitian, at an organisational level. Special or modified diets are catered for. Soft and pureed dietary needs are documented in files sampled. The cook interviewed was knowledgeable around resident preferences and residents who were losing weight. A dietary assessment is made by the RN as part of the assessment process and this includes likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. This includes consideration of any dietary needs (including cultural needs). This was reviewed six-monthly as part of the care plan review or sooner if required. There was evidence of residents receiving supplements. There is evidence that there are additional nutritious snacks available over 24-hours.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses (RNs) and care workers follow the care plan and report progress at each shift handover. All care plans reviewed included documentation that meets the need of the residents and had been updated as residents` needs changed. If external allied health requests or referrals are required, the registered nurses initiate the referral (e.g., wound care specialist, dietitian, hospice or mental health team), referrals and concerns are discussed at the regular multidisciplinary (MDT) meetings. The nurse practitioners (for service for older people and mental health services) interviewed on day of audit spoke highly of the service and confirmed they were informed of changes in resident condition They reported that the registered nurses are proactive and forward thinking to prevent residents condition deteriorating. The relatives interviewed agreed that the clinical care is good and that they are involved in the care planning. Care workers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies (sighted). Wound assessment, wound management, photos and evaluation forms are in place. Waimea (hospital) wing had seven wounds including: one stage 2 pressure injury, three skin tears, one previous pressure injury site requiring monitoring, and two chronic leg ulcers. The Charlton (rest home) wing had: one surgical wound and Oban (dementia) wing had: two skin tears and a scab requiring monitoring. Pressure injury equipment was in place for residents at high risk of developing pressure injuries. The wound care specialist had been involved for residents with chronic wounds. Care and support in the dementia unit was observed to be provided in a calm environment. Care workers, activity staff and registered nurses were all observed to interact with the residents. the relatives interviewed commented on the calm homely environment in the unit. Interviews with registered nurses and care workers demonstrated understanding of the individualised needs of residents for all levels of care provided. care plan interventions were individualised and comprehensive. There was evidence of two hourly turning charts, monthly weight and vital sign monitoring, and food and fluid charts, however the monitoring charts in place for the two residents using restraint were not consistently completed as instructed in the care plan.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activity programme is led by a team of two, one diversional therapist and an activities coordinator (interviewed) who has been in the role since March 2020. Both have first aid certificates and have completed the dementia standards. The team document activity assessments and prepare the quality-of-life care plans for each resident on admission and review at least six-monthly. Residents meetings are held three-monthly. The monthly activity programme is printed, and a copy is given to residents. The programme is varied and changes if the weather is not suitable. The programme runs from Monday to Friday, a weekly church service is held each Sunday. The programme included: exercises for large and small groups, newspaper reading, group games, and crafts. One on one sessions include hand massages and walks. Celebrations and special occasions are celebrated. There are displays in the themed corridor and resident room doors are decorated. All residents in the facility are invited to and can participate in larger events and celebrations held within the home. The physio assistant assists residents with their exercise programme designed by the physiotherapist. The activities coordinator has developed a new template that includes residents likes, dislikes and capability including anything hindering their participation such ‘as pain in left leg’. The purpose of this template is to support care workers or activities staff not familiar with the residents to run the programme in the absence of activity staff. The activities in Oban (dementia) wing included: daily newspaper reading, exercises, walks, group games, puzzles and board games. One on one activities include nail care, hand massages, using the foot spa and walks. The residents and the relatives were complimentary of the activities on offer. Volunteers are available to participate with activities including sing-a-longs, entertainment, supporting residents with happy hours and reading the newspaper. Schools and pre-schools visit the facility regularly. The residents on the accessibility contracts participate in the facility activities and are provided with magazines of their choosing. The activities coordinator interviewed described one on one activities for less able residents. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans reviewed for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. There is at least a three-monthly review by the medical practitioner. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Resthaven holds a current building warrant of fitness expiring on 24 June 2021. Preventative and reactive maintenance occur, and records are maintained as evidenced by the maintenance man. Hot water temperatures are checked randomly and were within ranges. Tradesmen are available if required. Equipment has been tagged and tested. All areas are accessible for residents using mobility aids. There is a large communal lounge area and several quiet areas for residents to enjoy a quiet more intimate space throughout the rest home and hospital wings. Outdoor areas and gardens are well maintained and accessible to residents. The gardens have seating and shade provided by the trees. There is a designated smoking area for residents. The Oban (dementia) wing is secured with keypad entry. The unit is spacious and has a large open plan lounge/ dining area and a smaller lounge for residents to use. The external garden area is secured. Residents were observed moving freely around the unit during the audit. The care workers interviewed stated they have sufficient equipment including mobility aids, hoists, wheelchairs and pressure injury equipment (if required), to safely deliver the cares as outlined in the residents’ care plans.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infections. All infections are entered into the electronic data system quarterly and are reported back to the facility. The infection control team meet monthly to address issues and an infection control report is given to staff meetings. There was a gastroenteritis outbreak in 2019. There was evidence of outbreak management, public health was informed, logs were maintained, and the outbreak was well managed. Extra education sessions were held around the Covid19 outbreak including donning and doffing of personal protective equipment. Residents, relatives and staff all stated they were well informed and kept up to date with the current guidelines. Wellness declarations, and contact tracing continue to be completed by all visitors and contractors to the facility. Adequate supplies of personal protective equipment were sighted, and a further stock is held centrally at the head office. There were no corrective actions identified at the DHB Covid 19 audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The restraint coordinator maintains a log of all restraints and enablers in use. There were two hospital residents using restraint. One resident was using bedrails and a wheelchair lap belt, and one resident was using a bedrail. Assessments and consents were signed by the enacted enduring power of attorney and the GP. The restraints have been monitored three-monthly. The care plan instructs the care workers on risks, and two hourly monitoring requirements (link 1.3.6.1). Restraints are discussed at the quality, clinical and staff meetings. There were no residents using enablers. The restraint coordinator (RN) attends restraint approval committee meetings. Restraint use is included in orientation for clinical staff. an education session was held on challenging behaviour in February 2020. restraint minimisation and safe practice competency has been completed by 44 staff.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Data around falls, wounds, infections and incidents are collated, analysed and trended each month by the clinical manager. Graphs of the data are available on the staff noticeboards; however, the minutes of the meetings do not reflect discussions held around quality data collected.  | There was no documentation in the registered nurses or care workers minutes of meetings to evidence discussions around quality data and analysis. | Ensure the minutes of meetings evidence discussions held around quality data and analysis. 180 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The interventions around restraint in the long-term care plan were detailed, included risks and two hourly monitoring.  | Two of two restraint monitoring charts and progress notes did not reflect two hourly checks as instructed in the long-term care plan | Ensure the monitoring charts and progress notes reflect care plan instructions90 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.

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| --- |
| No data to display |

End of the report.