# Waihi Senior Citizens Home Incorporated - Hetherington House

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Waihi Senior Citizens Home Incorporated

**Premises audited:** Hetherington House

**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: 17 May 2021 End date: 17 May 2021

**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:** 50

# 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

Hetherington House provides rest home, dementia and hospital level care for up to 50 residents. The service is operated by the Waihi Senior Citizens Home Incorporated Society and managed by a facility manager with support from a long term employed senior registered nurse.

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

Residents and families spoke positively about the care provided.

This audit identified two new areas for improvement. These relate to post falls recording and medicine recordings. The two previous improvements required relating to cleaning chemicals and interRAI assessments have been rectified.

## 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. |

Implemented systems and the environment is conducive to effective communication. The complaints management system meets the requirements of the Code and is known by staff, residents and their families. Residents and family members interviewed reported that the manager immediately responds to and addresses any concerns they raise.

## 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. |  | Standards applicable to this service fully attained. |

The annual business and quality risk management plans include the scope, direction, goals, values and mission statement of the organisation. Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes monitoring service delivery and other operations through internal audits. Quality improvement data is collected, analysed for trends and leads to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery.

The appointment, orientation and management of staff is based on good employment practices. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of 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 medium or high risk and/or unattained and of low risk. |

The registered nurses and general practitioners assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

The medication management policy guides staff in safe medicine management.

The food service meets the nutritional needs of the residents, with special needs catered for. Food is safely managed. Residents confirmed satisfaction with the meals.

## 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. |

There have been no changes to the structure of the buildings since the previous audit. A current building warrant of fitness is on display and planned and reactive maintenance is occurring.

## 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. |

The organisation has policies and procedures that support the minimisation of restraint. At the time of audit, three residents were using restraint interventions and one resident was using bedrails voluntarily at their request. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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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 surveillance undertaken is appropriate for the size of the facility. Infection results are reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 16 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 2 | 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 | The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed understood how to raise these.  The complaints register reviewed showed two complaints received this year and four complaints in 2020. None of these were escalated to the DHB nor the Office of the Health and Disability Commission (HDC). Each complaint had been acknowledged in writing, there were records of actions taken through to an agreed resolution with the complainant, and all steps in the process occurred within expected timeframes. The FM is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Interviews with residents and families confirmed their knowledge of the complaints process, and they said they wouldn’t hesitate to raise concerns. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the incident and accident records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services through the Waikato district health board and the contact number was available. Staff interviewed stated that interpreter services were however rarely required due to all residents able to speak English and staff being able to provide interpretation as and when needed. The registered nurses interviewed stated that there was good communication with families/whānau and families interviewed confirmed this. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The two year strategic plan is reviewed annually by the board and the facility manager (FM). This outlines the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of trustees contained extensive and detailed information, sufficient to monitor the organisations performance. This included the statistics and narrative analysis for incidents and accidents, infections, restraint, bed occupancy, staffing, financial performance, and any known emerging risks or issues.  The FM has extensive experience as a manager and registered nurse in aged care facilities and has not maintained a practicing certificate. This person has been in the role for three years and demonstrated knowledge of the regulatory and reporting requirements. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager maintains knowledge of the sector and currency about business and clinical practices by attending DHB forums, gerontology conferences and through on line education which meets and exceeds the ARCC requirement of attending eight hours professional development annually.  The FM is supported by a senior registered nurse, who was on leave and came in for the audit. The senior nurse oversees all clinical care and has been employed at Hetherington House for 19 years.  The service holds agreements and contracts with Waikato DHB and the MoH to deliver care for older people assessed as requiring rest home, dementia, hospital (medical and geriatric), respite, long term support-chronic health conditions (LTS-CHC) and for young people with disabilities. On the day of audit 50 residents in total were receiving services. These were 13 hospital residents (which included one person with a disability under 65 years of age) and 31 rest home residents (including one LTS-CHC person) and six residents in the dementia unit. There were no respite or palliative care residents. |
| 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 | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, infections, complaints, internal audit activities, regular resident, family and staff satisfaction surveys, and monitoring implementation of improvements to address any service shortfalls.  The sample of staff, RN, quality/risk and health and safety meeting minutes showed that essential information is presented. This includes the results of internal audits, trends in incidents and other quality data analysis, new service development or projects.  Board meeting minutes confirmed that they receive very detailed reports about findings from audits, surveys, complaints and incidents, each month staff reported their involvement in quality and risk management activities through carrying out internal audits, discussions at meetings and other day to day communications.  Staff, resident and family satisfaction surveys are conducted annually. The most recent November 2020 family survey (11 returns) revealed a high level of satisfaction. The 2020 resident food satisfaction survey (17 returns) did not raise any significant issues. Any issues/concerns reported are investigated by the FM and responded to where possible. Outcomes from all surveys are shared with the board and staff.  Policies are based on best practice and are current. These are standardised for the sector and cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The FM described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and there is a nominated health and safety officer who reports on and oversees safe work practices. |
| 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 | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. There was a finding in criterion 1.3.6.1 related to the frequency of completing neurological observations following unwitnessed falls or falls involving residents heads.  Adverse event data is collated monthly by the senior RN who provides a statistical and narrative analysis report to the FM and the Board.  The FM described essential notification reporting requirements and advised there had been one section 31 notification to the Ministry of Health and DHB since the previous audit. This was a stage three pressure injury reported in February 2021. There have been no police investigations, coroner’s inquests, issues based audits or any public health 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 | Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practicing certificates (APCs), where required. The sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Recently employed staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and an initial performance review after a three-month period.  Continuing education is planned on an annual basis, including mandatory training requirements.  Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. Of the 33 caregivers employed, 19 have completed the dementia unit standards (US 23920-23923) as has the EN and a number of RNs.  Ten caregivers have achieved level 4 of the national certificate in health and wellbeing, 10 have completed level 3 and 13 are at level 2. Three of the nine registered nurses employed are trained and maintaining their annual competency requirements to undertake interRAI assessments. Two more RNs are enrolled to begin their training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. |
| 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 documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are adjusted to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.  Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There are six caregivers rostered on morning shifts (three for rest home, two for hospital and one in the secure unit) plus one RN and the senior RN who works Monday to Friday. Five caregivers and one RN cover the afternoon shift and there is one RN and three caregivers at night.  All RNs maintain a current first aid certificate there is at least one staff member on duty with this.  The rosters confirmed that only staff who have completed or are progressing educational achievements in dementia care (US 23920-23923) work in the secure unit. The sole person allocated for eight hour shifts in the unit was observed to be provided regular breaks by other staff. |
| 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. | PA Moderate | Hetherington House has an electronic medication management system in place that was observed on the day of the audit. This was implemented in March 2021. The medication management policy was current and identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies.  The care staff who were observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolleys in the medication rooms in each unit. Staff have individual passwords to access the electronic medicine records. The medicine fridge and medication room temperatures were monitored, and the reviewed records were within the recommended ranges.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN completes medication reconciliation upon residents’ readmission from acute services and when medication is received from the pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy in a timely manner, there were no expired medicines in stock. Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Internal medication management audits were conducted, and corrective actions were implemented as required. Any medication errors were documented, and appropriate investigations were completed, and corrective actions were implemented.  Medication reviews were completed in a timely manner by the GPs. The pro re nata (PRN) medicines had indications for use documented. Administered PRN medicines were not consistently evaluated for effectiveness.  There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. Interviewed staff demonstrated awareness of the medication self-administration process. |
| 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 food service is provided on site by four cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a three weekly cycle and has been reviewed by a qualified dietitian in November 2019.  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with a current food safety plan and registration issued by the local district council. The food control plan expires in March 2022. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cooks have completed relevant food safety training.  Nutritional assessments were completed for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Nutritional supplements were provided for residents with weight loss issues. Residents in the secure unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet resident’s nutritional needs, was available.  Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews and satisfaction surveys. The food was served in the respective dining rooms and residents were offered extra servings if desired. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Nursing assessments are completed on admission using the organisation’s assessment tools, such as, a pain scale, falls risk, pressure area risk, nutrition, and continence assessments, as a means to identify any deficits and to inform care planning within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and six-monthly. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process. The previous area requiring improvement in relation to overdue interRAI assessments has been addressed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The interventions documented in the long-term care plans reviewed were adequate and appropriate to address residents’ assessed needs and desired outcomes. Observations and interviews with residents and family/ whānau verified that care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of residents’ individualised needs was evident in all areas of service provision. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet the residents’ needs. Post fall neuro-observations were not completed at the frequency and interval required by the organisation’s policy. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A social history assessment is completed on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Daily attendance records were completed and data from these was used as a basis for evaluation of residents’ activities plans. Reviewed activities plans were evaluated six -monthly as part of long-term care plan evaluation.  The activities programme is provided by an activities coordinator and a casual diversional therapist oversees the programme. The planned activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Activities on the programme included: bowls, exercises, movies, music, birthday celebrations, van outings, pet therapy, monthly theme celebrations and happy hour. Residents can attend to church services in the community if desired and there are regular onsite church services provided. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents were participating in a variety of activities on the day of the audit.  Activities are combined for external entertainment and held separately in each in each unit for daily activities. Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living with dementia. Activities are offered at times when residents are most physically active and/or restless. This includes painting, simple word games, music, and short walks. 24-hour activities plans were completed for residents in the dementia unit.  Residents and families interviewed confirmed they find the programme satisfactory. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes by the care staff. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes at least weekly and more frequently when indicated as determined by the resident’s condition. This was evidenced in the residents’ records reviewed.  The reviewed records showed that formal long-term care plan evaluations occur every six months following the six-monthly interRAI reassessments. InterRAI assessments are completed for significant change in residents’ condition and care plans reviewed and updated to reflect residents’ current needs. The evaluations indicated the degree of achievement or response to the interventions and/or support provided, and progress towards meeting the desired outcome.  Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Short term care plans sighted were for urinary tract, chest infections and wound infections. Residents and families/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 04 March 2022) is publicly displayed.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. There has been extensive refurbishment of the internal spaces, for example, new carpets and curtains in all communal areas, installation of ceiling hoists in each hospital bedroom, and purchase of 50 new beds.  There have been no structural changes to the building. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The previous area of improvement related to storage of cleaning chemicals and monitoring of this has been addressed. Visual inspection of cleaning trolleys, chemical storage areas and interviews with staff revealed that all chemicals were labelled and stored securely when not in use. Internal cleaning audits conducted since 2019 revealed no non-compliances. Additionally, all cleaning staff have achieved level two training in the national certificate in cleaning since the previous audit. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, systemic and the upper and lower respiratory tract. The infection control nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme is shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and this is reported to the facility manager, and a report is sent to the board monthly. Recommendations to assist in infection reduction and prevention were acted upon. Covid-19 pandemic contact tracing measures were implemented. There has been no reported infection outbreak reported since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator who is the senior RN, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and their role and responsibilities.  On the day of audit, three residents were using restraints (lap belts when seated and one bedrail) and one residents was using a bedrail voluntarily at their request as an enabler. All of these were the least restrictive option. A similar process is followed for the use of enablers as is used for restraints.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. |

# 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 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Allergies were documented on the electronic medication charts sighted. The uploaded residents’ photos were current. The prescriber’s signature and dates for the commencement and discontinuation of medicines were documented on the electronic medicine charts sighted. The required three-monthly GP reviews were consistently recorded on the medicine chart. The PRN medicines were administered as required; however, the administered PRN medicines were not consistently evaluated for effectiveness. | Eight out of 10 sampled medication charts did not have consistent evaluation of the administered PRN medicines. These medicines included pain relief, behaviour management and bowel management medicines. | Provide evidence that administered PRN medicines are consistently evaluated for effectiveness.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The interviewed residents and family/ whānau confirmed that the services provided, and interventions implemented meet their assessed needs and desired outcomes. The organisation’s policy stated that neurological monitoring is to be completed for residents who have unwitnessed falls, or those who hit their head during the fall, and this serves as a guide for staff. The specified regime for completing the neurological observations for residents who had unwitnessed falls or hit their head during the fall were not completed as specified in the policy in the four incident forms reviewed. | Four incident reports related to falls did not have neurological monitoring completed at the frequency and interval required by organisational policy. | Ensure the frequency and timing of neurological observations occurs according to policy.  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.