# Presbyterian Support Services Otago Incorporated - Holmdene Rest Home

## 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 Otago Incorporated

**Premises audited:** Holmdene Rest Home

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

**Dates of audit:** Start date: 18 October 2021 End date: 19 October 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:** 33

# 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

Holmdene Rest Home is part of the Presbyterian Support Services Otago group of aged care facilities. The care facility has a total of 35 beds suitable for rest home and hospital level care. On the day of audit there were 33 residents,

This surveillance audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included the review of residents’ and staff files, observations, and interviews with residents, a relative, staff, management, and a general practitioner.

The facility manager is a registered nurse who has been in this role for one year and is an experienced registered nurse and clinical manager. The facility manager is supported by a clinical coordinator/RN. Support from the central office includes a quality advisor and clinical nurse advisor, Enliven Administrator and the Director of Enliven services

There are well-developed systems, processes, policies, and procedures that are structured to provide appropriate quality care for people who use the service, including residents that require hospital/medical, and rest home level care. Implementation is supported through the PSO quality and risk management programme that is individualised to Holmdene Rest Home.

This audit identified one area requiring improvement around timeframes for completion of documentation.

Two previous findings relating to monitoring documentation and hot water temperatures have been met.

## 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. |

Policies are implemented to support residents’ rights, communication, and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

## 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 facility manager is supported by a clinical coordinator, registered nurses, care workers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. A comprehensive education and training programme is implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

## 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. |

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent care workers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The activities coordinator provides and implements an interesting and varied activity programme. The programme includes community visitors and outings when Covid alert levels allow. Entertainment and activities are provided to meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each resident group.

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

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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. |

The building holds a current warrant of fitness. Maintenance is undertaken on a scheduled and as required basis. Hot water temperatures are monitored.

## 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. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident using restraint and no residents with an enabler.

## 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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control. Covid-19 alert level plans are in place and the service has sufficient supplies of PPE on hand.

## 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 | 15 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 1 | 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 policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and family demonstrated their understanding of the complaints process. All staff interviewed (three care workers, two registered nurses, one administrator, one kitchen manager and one activities coordinator) were able to describe the process around reporting complaints as were the managers (clinical coordinator and PSO clinical advisor).  There is a complaint register. One complaint has been lodged in 2021 (year to date) and none for 2020. The 2021 care-related complaint has been responded to, investigated, and resolved to the satisfaction of the complainant.  Complaints are linked to the quality and risk management system. Discussions with residents and relative confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.  There have not been any complaints lodged by external providers since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Six residents (two rest home and four hospital) interviewed stated they were welcomed on entry and were 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 and frank open disclosure occurs. A record of family communication is indicated by a specific progress note documented in each resident’s file.  Twelve incidents/accidents forms selected for review indicated that family were informed. One family member interviewed confirmed they are notified of any changes in their family member’s health status.  Interpreter services are available if needed. Staff and family are utilised in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Holmdene Rest Home (referred to in the report as Holmdene) is part of the Presbyterian Support Services Otago (PSO) group of aged care facilities. The care facility has a total of 35 beds suitable for rest home and hospital level care (including medical). All of the beds are dual-service beds (hospital and rest home).  On the day of audit there were 12 rest home level residents and 21 hospital level residents. All residents were funded through the Age-Related Residential Care Agreement (ARRC).  Presbyterian Support Otago has a current strategic plan, a business plan, and a quality plan for 2021/2022. There is a Holmdene specific quality plan that links to the organisational plan. Holmdene quality plans include continuing with benchmarking data, decreasing incidence of pressure injuries, improving the tea meal time, and decreasing skin infections. Additional plans include training and staff development, as well as improving resident satisfaction. Achievement towards goals is included in a monthly report to the PSO quality advisor.  The facility manager is a registered nurse who has experience in management and aged care and has been in the role since September 2020. The facility manager was unavailable during the audit. She is supported by a clinical coordinator. The clinical coordinator is a registered nurse, who has been in the position for two years. The facility manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place and well embedded in practice. Interviews with the clinical coordinator and staff confirmed their understanding of the quality and risk management systems.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.  Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed with results communicated to staff. Corrective actions are implemented where benchmarked data exceeds targets.  An internal audit programme is in place. In addition to scheduled monthly internal audits, six monthly wellness checks are undertaken (a PSO full audit process). Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented. Quality and risk data is shared with staff via meetings and posting results in the staff room.  Presbyterian Support has a strong H&S commitment and committees. There is a central health & safety committee that has representation from a manager of an Enliven care home. Holmdene has a health and safety committee that meets bi-monthly. All committee members have completed the health and safety unit standard "Describe the role and functions of the H&S representative in a NZ workplace”. The facility manager has attended updates on health and safety procedures during managers days in Dunedin.  Strategies are implemented to reduce the number of falls. This includes (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities and physiotherapy input. The clinical coordinator reviews all falls and documents a monthly report. This report documents all individual falls, issues around the fall and any corrective plans that have been undertaken. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Care worker interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers. |
| 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 | There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all twelve accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls are followed with a set of neurological observations conducted as evidenced in the sample of incident reports reviewed.  Discussion with the clinical coordinator and the clinical advisor confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. Two section 31 for an unstageable pressure injury and an outbreak notification for respiratory outbreak in September 2020 were confirmed as being sent. The Ministry of Health was also informed of the appointment of the facility manager. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience, and veracity. A register of current practising certificates is maintained. Five staff files reviewed (one weekend cook, two care workers, one registered nurse and the clinical coordinator) evidenced that reference checks were completed before employment was offered. Also sighted were signed employment agreements and job descriptions.  The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Staff orientations were fully completed, including three monthly post-employment reviews. The service provides four block education days a year where care staff are rostered to the day and paid to attend. Registered nurses and senior care workers complete medication training and competencies. Registered nurses have syringe driver training and competencies completed. All training is entered onto a database. The cook has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on site. Chemical safety training is included in staff orientation and as a regular in-service topic.  Staff are able to attend external training including sessions provided by the district health board and online training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents.  The facility manager and clinical coordinator are registered nurses with current practising certificates who work full time Monday – Friday. The registered nurses are rostered separately to care workers; there is at least one RN rostered on each shift. Four times a week there is an extra registered nurse rostered on in the mornings to complete interRAI assessments and paperwork.  Care workers work as one team with three long and three shorter shifts on each morning shift: five care workers in the afternoon on two long and three shorter shifts, and one care worker on at night with the night RN.  Extra staff can be called on for increased residents' requirements.  The activities coordinator works five days a week. Separate cleaning, kitchen and laundry staff are rostered.  Interviews with staff, residents and a family member identified that staffing is adequate 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 guidelines. Clinical staff that administer medications (RNs and occasionally some care workers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medications are stored safely.  The medication fridge is maintained within the acceptable temperature range. The medication room temperature is monitored, and all recordings show that the room is kept at 25 degrees Celsius or below. All eye drops and ointments were dated on opening. There was one resident self-medicating inhalers only on the day of audit; competencies had been undertaken for this resident that had been reviewed three-monthly. The medications were stored safely.  Ten electronic medication charts reviewed met legislative requirements. Medications had been signed as administered in line with medication charts. Appropriate practice was demonstrated on the witnessed medication round. |
| 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 | All meals are prepared and cooked on site. The kitchen is led by the food services manager. Food services staff have attended food safety and chemical safety training. There is an approved food control plan in place that expires on 1 February 2022. There is dietitian input into the provision of the menus and diets where required. The PSO dietitian prepares and reviews all menus for the group with this last completed in November 2020.  A full dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically as part of the care planning review process. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture requirements.  Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely.  Residents can attend the dining room for their meals, or they may have meals delivered to them on a tray. A caregiver is always present in the dining room while the residents are having breakfast and assists in serving residents that are not able to be independent. There were two dining areas; one dining area was used for residents that required assistance with feeding; and the other dining area was for the residents who were more independent.  Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, a registered nurse initiates a review and if required a GP consultation. There is documented evidence on the family/whānau contact form in each resident file that indicated family were notified of any changes to their relative’s health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals, and changes in medications. Discussions with family confirmed they are notified promptly of any changes to their relative’s health.  Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for the eight residents with nine wounds (skin tears, skin lesions, ingrown toe nail, and three pressure injuries).  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences.  Short term care plans are developed and included infections and wounds. Monitoring forms are used for weight, vital signs, blood sugar levels, pain, challenging behaviour, food and fluid charts, neurological observations and repositioning charts as evidenced in the five files reviewed. The service has addressed the previous finding. |
| 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 | There is currently one activities staff employed (with one on maternity leave) who provides activities at PSO Holmdene. She is supported by care workers and a team of volunteers. The activities programme covers five days a week. There is a weekly plan of activities, based on assessed needs and wishes of the residents. This is posted on the hallway noticeboard and residents have a copy of the programme in their rooms.  Activities include newspaper reading; exercises; bible studies; reminiscing and housie. On the days of audit, residents were observed being actively involved with a variety of activities. The programme includes residents being involved within the community, social clubs, church, and schools as Covid-19 alert levels allow. Visiting entertainers are currently on hold from attending the facility. Holmdene has a church service once a week.  Residents have an initial assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and life events. Activities are included as appropriate in the lifestyle support plan. A record is kept of individual resident’s activities and progress notes completed.  Feedback about the activities programme is gained from the residents individually and in resident meetings. Residents interviewed spoke very positively about the varied activities programme which they have input into. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Most initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed (link 1.3.3.3). Not all long-term care plans have been evaluated by an RN six monthly or earlier for any health changes (link 1.3.3.3). Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been involved in the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and on the long-term care plan. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a building warrant of fitness that expires October 2022. The service contracts a maintenance person for 40-50 hours per month who undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment, and safety checks. Hot water temperature records reviewed evidenced that records were noted to be at or just below the required 45 degrees centigrade. Where temperatures were recorded more than this level, a corrective action had been implemented with a plumber and testing evidenced that the levels had been rectified. The service has addressed this previous finding. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours.  The facility has wide corridors with enough space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas, which include a courtyard. Seating and shade are provided.  The care workers and RNs stated they have enough 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The clinical coordinator is the infection control coordinator and along with the facility manager, uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly log of infections and short-term care plans are completed for all resident infections. Infection control data is collated monthly and reported at the quality and risk, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Infection control data is on display for staff. The infection control programme is linked with the adverse event reporting system. The results are subsequently included in the manager’s report on clinical indicators.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. One respiratory infection outbreak during 2020 was reported to Public Health and the DHB and was managed well.  The service has clearly defined pandemic plans for Covid-19 alert levels and has procured sufficient supplies of PPE. Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Covid isolation kits have been put together in readiness, and education and training for staff has been provided. All visitors must register at reception and be screened. Covid vaccinations have been provided for staff and residents. The service maintains a large supply of outbreak management resources, which includes but is not limited to special bins with lids, antibacterial wipes, clothing protectors, gowns, surgical masks, N95 masks, gloves, specific bags for contaminated items, antibacterial gels, and sprays. The five moments of hand hygiene were observed to occur when delivering personal cares in residents’ rooms. |
| 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. There was one hospital level resident with bed rails identified as restraint and no residents using an enabler.  Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. |

# 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 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Five resident files were reviewed and all evidenced that interRAI assessments, risk assessments, long-term care plans and short-term care plans have been completed and align with the needs of the residents. One of the five files evidenced that interRAI assessments and long-term care plans have been completed within the required contractual timeframes. Not all files evidenced that assessments and care plans align, or that interRAI assessments inform the development or evaluation of the long-term care plans. | i) One rest home and one hospital file did not have interRAI or the long-term care plan completed within 21 days of admission; ii) one hospital resident’s interRAI reassessment was completed after a gap of nine months; iii) two hospital level files interRAI assessments and long-term care plans did not align, with gaps of over two months between each documentation completion. | i)-iii) Ensure that all aspects of assessments and care planning are completed within required timeframes and that interRAI assessments inform the development and review of the long-term care plan.  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.

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| No data to display |

End of the report.