# Eastcliffe Orakei Management Services LP

## Introduction

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

The audit has been conducted by Health Audit (NZ) 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:** Eastcliffe Orakei Management Services LP

**Premises audited:** Eastcliffe on Orakei

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

**Dates of audit:** Start date: 29 January 2015 End date: 30 January 2015

**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:** 26

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Eastcliffe on Orakei has the capacity for 28 residents requiring hospital or rest home level care with 26 residents in the care unit on the days of the audit. This certification audit was completed against the Health and Disability Sector Standards and the District Health Board contract requirements.

The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The nurse manager provided operational management of the care unit with the clinical manager newly appointed and providing clinical oversight. Staffing levels were reviewed for anticipated workloads and acuity.

Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, completion of internal audits and satisfaction surveys.

Improvements are required to the agreements, the Maori health plan and training around restraint.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

Staff demonstrated an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Residents were treated with respect and received services in a manner that considered their dignity, privacy and independence. Information regarding resident rights, access to advocacy services the complaints process was available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs were assessed on admission. Informed consent policy and processes were implemented by the service with advance directives documented when residents were competent.

Staff ensured residents were informed and had choices related to the care they received.

Improvements are required to the resident agreements and to review the Maori health plan and documentation of cultural and spiritual aspects of care.

## Organisational management

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

The service had a documented quality and risk management system that supported the provision of clinical care and support. Policies were reviewed and quality and risk performance was reported through regular meetings. The managers reviewed and monitored service delivery through internal audits, complaints, health and safety and feedback from residents and family.

There were human resources policies implemented. The service had in place an orientation/induction programme that provided new staff with relevant information for safe work practice and there was an ongoing training programme.

Staff identified that staffing levels were adequate and interviews with residents and relatives demonstrated that they had adequate access to staff to support residents when needed.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Care and support was provided by a range of health professionals. Clear time frames for service provision were defined and monitored. Lifestyle plans and interventions were current and sufficiently detailed to meet the health and wellbeing of residents.

Activities were planned to meet the needs of the resident. Individual activity goals were documented and ensured the provision of relevant and appropriate activities. Previous interests, hobbies, culture and ability was considered. Sufficient activities and outings were provided and participation in activities was voluntary.

A safe medication management system was in place. The required policies and procedures were documented and available to staff. All medications were stored securely. All staff involved in the administration of medications had current competencies.

Food services were provided by an external provider. Food and nutritional needs of residents were assessed. Special needs were catered for and monitored. Food preparation and storage met food safety requirements

## Safe and appropriate environment

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

All building and plant complied with legislation with a current building warrant of fitness. There was a reactive and preventative maintenance programme including equipment and electrical checks.

Residents rooms were of an appropriate size that allowed care to be provided and for the safe use and manoeuvring of mobility aids. Activities occur in any of the lounges and furniture was arranged that ensured residents were able to move freely and safely.

Laundry was completed on site and managers and staff monitored cleaning to ensure that the facility was cleaned to a high standard.

Essential emergency and security systems were in place with regular fire drills completed. Call bells were in place.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

There were documented guidelines on the use of restraints and enablers. Alternatives to restraint were is use. There were three residents with bed rails in place. These were being used safely. An improvement is required to ensure staff awareness of restraints and enablers.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme was clearly documented and was suitable for a hospital/rest home setting. Infection rates were monitored and data analysed for trends and improvement purposes. Staff received training on infection prevention and control. There had been no infection outbreaks since the last certification audit.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 47 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 98 | 0 | 3 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](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).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The clinical/quality manager, nurse manager and/or a registered nurse discussed the Code, including the complaints process with residents and their family on admission.  Discussions relating to the Code could also be held at the residents' meeting. Residents interviewed confirmed their rights are being upheld by the service.  Resident rights to access advocacy services were identified for residents and advocacy service leaflets were available at the entrance to the service. If necessary, staff will read and explain information to residents as stated by staff interviewed.  Information was also given to next of kin or enduring power of attorney (EPOA) to read to and discussed with the resident in private.  Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Residents and their families were provided with all relevant information on admission.  Discussions were held regarding informed consent, choice and options regarding clinical and non-clinical services.  Informed consent obtained included the following: consent for sharing of information, consent for care and treatment, indemnity and outing consent. There were advance directives documented if the resident was deemed competent.  Admission agreements sighted had all been signed.  Discussions with residents and relatives identified that the service actively involved them in decisions that affected their lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office was provided to residents and families. Resident information around advocacy services was available at the entrance to the service.  Staff training on the role of advocacy services was included in training on the Code – last provided for staff in April 2014.  Family and residents identified that the service provided opportunities for the family/EPOA to be involved in decisions and they stated that they had been informed about advocacy services.  The resident file included information on resident’s family and chosen social networks.  Staff interviewed were aware of the right for advocacy and how to access and provide advocacy information to residents if needed. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service had an open visiting policy. Residents may have visitors of their choice at any time. The facility was secured in the evenings but visitors could arrange to visit after doors were locked.  Families interviewed confirmed they could visit at any reasonable time and were always made to feel welcome. Family were seen coming and going freely on the days of the audit.  Residents were encouraged to be involved in community activities and maintained family and friends networks. Links were also encouraged with some residents still engaged in community activities.  Residents were included in outings with family members. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation’s complaints policy and procedures was in line with the Code and included time frames for responding to a complaint. Complaint’s forms were available at the entrance to the facility.  A complaints register was in place and the register included the date the complaint was received; the source of the complaint; a description of the complaint; actions; and the date the complaint was resolved. Evidence relating to each lodged complaint was held in the complaint’s folder. A review of a complaint indicated that the complaint was investigated promptly with the issue resolved in a timely manner.  Residents and family members stated that they would feel comfortable complaining and one verbal complaint was documented on the day of the audit and was managed immediately.  There had not been any complaints from the Health and Disability Commissioner, police, coroner, ACC, district health board or Ministry of Health since the last audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The clinical/quality manager, nurse manager and/or a registered nurse discussed the Code, including the complaints process with residents and their family on admission.  Discussions relating to the Code could also be held at the residents' meeting. Residents interviewed confirmed their rights are being upheld by the service.  Resident rights to access advocacy services were identified for residents and advocacy service leaflets were available at the entrance to the service. If necessary, staff will read and explain information to residents as stated by staff interviewed.  Information was also given to next of kin or enduring power of attorney (EPOA) to read to and discussed with the resident in private.  Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service had a philosophy that promoted dignity and respect and quality of life.  The service had policies and procedures that were aligned with the requirements of the Privacy Act and Health Information Privacy Code.  Resident support needs were assessed using a holistic approach. The initial and on-going assessment included gaining details of people’s beliefs and values with the staff stating that the care plans were completed with the resident and family member (confirmed by residents and family interviewed). Interventions to support these were identified and evaluated.  Residents were addressed by their preferred name and this was documented in files reviewed.  A policy was available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour. Training was provided to staff in December 2014.  The service ensured that each resident had the right to privacy and dignity, which was recognised and respected. The residents’ own personal belongings were used to decorate their rooms. Discussions of a private nature were held in the resident’s room and there were areas in the facility, which could be used for private meetings.  Caregivers reported they knocked on bedroom doors prior to entering rooms, ensured doors were shut when cares were being given and did not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirmed the resident privacy was respected.  Staff, residents and family report that residents' are encouraged to be as independent as possible with community activities and resources accessed by residents.  The service was committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff could describe the policy around abuse and neglect and all interviewed including the general practitioner stated that there was no evidence of abuse or neglect. Staff received education and training on abuse and neglect during their induction to the service and in the training programme provided by the organisation – last provided in November 2014.  Resident files reviewed identified that cultural and /or spiritual values and individual preferences were identified.  There were weekly church services with some residents attending community churches. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | PA Low | Eastcliffe on Orakei is owned by Ngati Whatua o Orakei and all residents are regarded as being a part of the Orakei marae. Kuia and Kaumatua of Ngati Whatua o Orakei were available to provide advice and support as required.  The managers stated that they implemented the Maori health plan and cultural safety procedures to eliminate cultural barriers however there was no documented evidence of review of the plan. The rights of the residents/family to practise their own beliefs were acknowledged by managers and staff.  The site and/or rooms were blessed by staff members who were able to complete this task.  There were two Maori residents living at the facility during the audit and one staff member who identified as Maori. The file of one resident who identified as Maori indicated that there was an emphasis on whanau/family engagement and on providing any specific cultural interventions identified by the resident and/or whanau.  Staff were aware of the importance of whanau in the delivery of care for their Maori residents.  Staff had received training around cultural aspects of life last in November 2014. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identified each resident’s personal needs and desires from the time of admission. This was completed with the resident, family and/or their representative. There was a culture of choice with the resident determining when cares occurred.  Residents and family were involved in the assessment and the care planning processes. Information gathered during assessment included the resident’s cultural values and beliefs. This information was used to develop a care plan and included input from the resident and their family.  Staff described professional boundaries and their roles and responsibilities.  There was a diversity of ethnic backgrounds identified by staff including Zimbabwean, Pacific Island, New Zealander, Pilipino and Indian. Most staff spoke another language apart from English. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implemented policies and processes that ensured that staff were aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Training included discussion of staff roles and behaviour that included bullying – last in 2014.  Job descriptions included responsibilities of the position, ethics, advocacy and legal issues with a job description sighted in all staff files reviewed.  The orientation and employee agreement provided to staff on induction included standards of conduct.  Interviews with staff and managers confirmed their understanding of professional boundaries, including the boundaries of the caregiver role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Policies aligned with the health and disability services standards and were reviewed annually to two yearly and as changes in legislation and evidence based practice occurred. There was a quality framework that supported an internal audit programme.  There was a training programme with sessions well attended.  Residents and families interviewed expressed a high level of satisfaction with the care delivered. The general practitioner also expressed a high level of satisfaction with the service.  The service had worked to address recommendations that had arisen from complaints and other aspects of the quality programme with a focus on the following: i) improvements in documentation, ii) improvements in assessments and medication management, iii) increased training around workplace bullying, v) a change in food services provider in response to feedback received. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurred. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family were informed if the resident had an incident, accident, had a change in health or a change in needs as evidenced in 20 completed accident/incident forms and through discussions with all family.  Family contact was recorded in residents’ files. Family were involved in the care planning process.  Interpreter services were available when required from the District Health Board. There were no residents requiring the use of interpreting services. The information pack was available in large print and advised that this could be read to residents. Interpreting services for Maori could be accessed from the neighbouring marae.  Staff have had training around communication in August 2014 and January 2015.  Residents signed an admission agreement on entry to the service. The signed page only was in the resident file and this did not link to the contract document. The agreements were in the name of the previous owner. |
| 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 facility is owned by Ngati Whatua Orakei through Eastcliffe Orakei Management Services LP.  The manager's job description identifies the experience, responsibility and authority required for the role. The nurse manager has been in the role for 13 years and has completed more than eight hours of relevant clinical and management education each year.  The service has a philosophy and values documented. A business plan was reviewed by the nurse manager annually.  The facility can provide care for up to 28 residents with 18 rooms identified as dual purpose (able to provide rest home and hospital level of care). During the audit there were 26 residents living at the facility including 5 residents requiring rest home level of care and 21 residents requiring hospital level of care.  The nurse manager is responsible for the overall management of the site with support from the clinical manager.  A monthly email note was sent to the general manager of Eastcliffe on Orakei giving notice of any issues that would need escalating. The general manager stated that this is the requirement explicitly requested by the governing body with it also stated that if there were any concerns, then these would be escalated formally. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical manager was designated as the second in charge. The clinical maanger was appointed two months prior to the audit and had previous experience as the manager at an aged care faciltiy, for three years with previous senior roles at the District Health Board. A hand over process was described. The clinical manager was a registered nurse with an advanced diploma in nursing.  A job description was sighted. |
| 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 | There was a documented quality and risk management framework that was documented to guide practice.  The business plan was documented and reviewed by the nurse manager.  The service implemented organisational policies and procedures to support service delivery. All policies were subject to reviews as required with all policies current. Policies were linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines.  Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, implementation of an internal audit programme with corrective action plans documented. The service graphed data with this discussed through a range of meetings including staff and registered nurse meetings. Meeting minutes evidenced communication with staff around all aspects of quality improvement. Corrective action plans were documented with evidence of resolution of issues. Residents and family described having input into quality improvement through the annual satisfaction surveys and six monthly resident meetings. Staff stated that they received feedback on clinical indicators and quality improvement through meetings attended.  The organisation has a risk management programme in place that included health and safety policies and procedures, documentation of hazards proactively and reactively and an organisational risk management plan reviewed by the board and leadership team. |
| 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 nurse manager and clinical manager were aware of situations where the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks.  The service was committed to providing an environment in which all staff were able and encouraged to recognise and report errors or mistakes and were supported through the open disclosure process.  Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events.  Ten incident reports had a corresponding note in the progress notes to inform staff of the incident and any incidents were discussed at handover. There was evidence of open disclosure for each recorded event.  Information gathered was regularly shared through meetings with graphs described by staff as providing a platform for discussion. |
| 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 | The registered nurses and the managers held current annual practising certificates. Visiting practitioner’s practising certificates were on file.  Staff files included appointment documentation and there was an appraisal process in place. Staff had an annual performance appraisal.  First aid certificates were held in the staff files.  All staff completed an orientation programme with the clinical manager facilitating an annual training plan (refer 2.1.1). Staff attendance was documented on attendance registers and on an excel spreadsheet. Caregivers were paired with a senior caregiver for shifts as part of orientation and a new staff member employed described a thorough orientation process.  Annual medication competencies were completed for all registered nursing staff.  Staff stated that they valued the training. Education and training hours exceeded eight hours a year for all staff with registered nurses accessing training relevant to their role. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy was the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. Staff were replaced when on leave.  There were a total of 27 staff including the registered nurses, clinical manager and nurse manager. There was an on call system with clinical staff providing support when required.  Residents, family members, the general practitioner and staff confirmed staffing was adequate to meet the residents’ needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retained relevant and appropriate information to identify residents and track records. This included comprehensive information gathered, at admission, with the involvement of the family. There was sufficient detail in resident files to identify residents' on-going care history and activities. Resident files in use were appropriate to the service.  There were policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information could be accessed in a timely manner.  Entries were legible, dates and signed by the relevant staff member including designation.  Resident files were protected from unauthorised access by being locked away in an office. Informed consent was obtained from residents/family/whanau on admission to care. Individual resident files demonstrated service integration. Medication charts were in a separate folder with medication and this was appropriate to the service. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry to service was facilitated in a timely manner. Adequate and accurate information about the service was provided. The pre-entry policy included entry criteria, assessment and entry screening processes. All residents were screened for eligibility and level of need prior to entry. This was confirmed in resident files sampled.  In interview, the manager reported that information about the service was known and disseminated throughout the community. This included information on bed numbers and availability. Residents residing in the serviced apartments were prioritised.  In interview, a family member reported that the entry process was conducted in a timely and comprehensive manner. The required information was made available. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Staff facilitated planned discharges in collaboration with the resident/family. There were policies and procedures to ensure exit, discharge or transfer of residents was undertaken in a safe manner. There was a specific transfer and discharge procedure which documented the needs and requirements of residents during this process to ensure continuity of care. Risks were identified prior to a planned discharge. There was open communication between staff and family relating to all aspects of care including exit, discharge or transfer. This was confirmed in interview with family members. The GP interviewed confirmed involvement in the discharge/transfer process. |
| 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 | Policies and procedures for medicine management met legislative requirements and safe practice guidelines. A pre-packed medication system was implemented. All medicines were prescribed by the GP. Prescriptions were legible, signed and dated appropriately. Medication records included allergies and administration records were maintained. Three monthly medication reviews were evident.  Medications were stored securely and safely in the nurses’ station. There was limited stocked medication kept on site. These mainly consisted of antibiotics for hospital residents. The medication cupboard was checked and confirmed all non-packaged medication was within the expiry date. The medication fridge was maintained at a stable temperature. The process of obtaining a telephone order from the GP was sampled and completed as per policy requirements. Standing orders met the current guidelines.  Controlled drugs were safely stored. A controlled drug registers was maintained. The required pharmacy checks of controlled drugs were being conducted and recorded.  Medications were administered by the registered nurses. Competencies for medication management were assessed by the nurse manager annually. A lunch time medication round was observed. It is noted that best practice was maintained.  The requirements for self-administration of medication were defined. There were no residents self-administering medication at the time of the audit. |
| 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 nutritional needs of residents were met. The residents nutritional status was assessed on admission and needs were identified. Nutritional intake care plans were sighted in resident files. Level of assistance required was recorded. All residents were weighed monthly. In the event of unexplained weight loss, or gain, a weight loss chart was developed indicating percent of change and required interventions. Fluids and snacks were readily available at all times.  All food services were contracted to an external provider. The chef and area manager were interviewed. The menu was based on a five week cycle. The menu plans were conducive for residents in an aged care residential setting and have been reviewed/audited by a dietitian to ensure appropriateness. The kitchen was maintained in line with the external provider’s contract requirements. This included complying with food hygiene standards and employing competent staff. Internal audits were regularly conducted to ensure compliance requirements were met. These included stock control and temperature monitoring.  Satisfaction surveys sighted confirmed general satisfaction with the food. This was confirmed during interviews with residents and family members. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | Any consumer declined entry to the service was informed by nurse manager. The nurse manager reported that declines to entry only occurred if the consumer was not eligible or there were no available beds. All prospective (eligible) residents were notified and contact records were maintained. Information regarding other facilities in the area was provided if required. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | A number of nursing assessments were completed on admission and InterRAI assessments were sighted. Resident information gathered also included a personal profile, social interests and observations of health status. An activities assessment, medical assessment and physiotherapy assessment were also developed. The required assessments, including those conducted by the needs assessors, were sighted in all resident files sampled.  The results of the assessment process were transferred onto the lifestyle care plan with outcomes and goals documented. Assessments were then reviewed during the lifestyle care plan review (or as required). Residents and family interviewed reported involvement in the assessment process, and confirmed that there were adequate areas to ensure assessments were conducted in private. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Lifestyle care plans included all personal details, nursing diagnosis, allergies and family/whanau input. Goals were documented, with the required interventions for each section. Additional short term care plans were developed as required. These were signed off when the short term need had resolved. For example: in the event of a wound or an infection.  Resident files were integrated and included information from allied health providers. Lifestyle care plans were cross reference to additional plans/interventions where these were required. For example: restraint monitoring charts, medication charts and observation recordings.  Residents and family interviewed confirmed their involvement in the care planning process. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Lifestyle care plans included concerns/problems, nursing goals and resident goals. Interventions were documented and addressed in each domain/goal or identified problem. Interventions sighted were consistent with best practice when working with older adults. The GP interviewed was satisfied that clinical interventions were implemented in a timely and competent manner. Interventions from allied health providers were given due consideration and this was evident in the files sampled. |
| 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 | The activity programme was developed and coordinated by the activities coordinator. The activities coordinator was on site three days per week. Care giving staff confirmed their involvement in supporting the programme in the absence of the coordinator.  Activity plans included a sufficient range of planned activities to develop and maintain strengths and interests. Regular exercises and outings were provided for those able to participate. A wide range of group activities was consistently provided. In addition, each resident had a social history/activities assessment completed on entry. From this an individual activities care plan, and goals, were developed. Participation in activities was monitored and the review process included an evaluation towards activity goals. All residents’ files sampled had the required activities assessments and reviews.  The monthly diversional activities reports for 2014 were sighted. These reported on the aims and achievements of the programme and confirmed a fully functional programme was in place. Residents interviewed were satisfied with the activities provided and confirmed that participation was voluntary. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The care review process ensured a comprehensive review of care was conducted every six months. Reviews were conducted by the nurse manager and included input from the staff, the resident and family. Care reviews included a review of recent medical history, brief social background, current health status, presenting issues/concerns and care needs, outcomes and any follow up actions required. Care reviews were sighted in resident files sampled and lifestyle care plans were updated when required.  In addition, lifestyle care plans were reviewed by the registered nurse every three months to ensure currency, and daily checklists were completed by the care givers. These indicated achievement in maintaining activities of daily living. Wound and infection care plans were evaluated as and when required. Three monthly GP reviews were also evident in resident files sampled. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Resident support for access or referral to another health and disability providers was facilitated timely and safely. Associated records were maintained. A referral process existed for referring residents to another health and disability services if required. A copy of the referral letter completed by the GP was kept with the resident’s records. The referral process was sighted and evident in a number of resident files sampled. The GP interviewed confirmed involvement in the referral process. In interview, residents and family confirmed that they can access the services of their choice. The cost for accessing services over and above those publically funded was outlined in the resident agreement. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances were in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and were free from damage.  Material Safety Data sheets were available throughout the facility and accessible for staff. The hazard register was current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances.  The provision and availability of protective clothing and equipment that was appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing was provided and used by staff. During a tour of the facility, protective clothing and equipment were observed in all high-risk areas. |
| 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 was posted in a visible location at the entrance to the facility (expiry date 21 November 2015). There had been no building modifications since the last audit.  A lift was used and the certificate on the lift was dated as October 2014.  There was a planned maintenance schedule implemented. Staff document any issues and the maintenance staff address these in a timely manner.  Equipment was available to meet resident needs with a test and tag programme that was up to date. Calibration of medical equipment was completed annually with the external providing confirming that they had appropriate equipment.  Interviews with staff confirmed there was adequate equipment.  There were quiet areas throughout the facility for resident and visitors to meet and there were areas that provide privacy when required.  There were safe outside areas that were easy for residents and family members to access and decks off each lounge on all floors.  There was a swimming pool and spa pool that could be used by residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There were adequate numbers of accessible toilets/bathing facilities. This included ensuites in all rooms. Communal toilets were conveniently located close to communal areas with a system that indicated if it was engaged or vacant.  Appropriately secured and approved handrails were provided in the toilet/shower/bathing areas, and other equipment/accessories were made available to promote resident independence.  Residents and family members interviewed reported that there were sufficient toilets and showers. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There was adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.  Equipment was sighted in rooms requiring this with sufficient space for both the equipment e.g. hoists, at least two staff, and the resident.  Rooms could be personalized with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.  There was sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service had lounge/dining areas on each floor. Residents could choose whether to have meals in the dining areas or in their rooms.  Lounge areas were large enough to hold activities with appropriate floor coverings. All areas were easily accessed by residents and staff.  Furniture was appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.  There was a specific area for the hairdresser. |
| 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 | There was a laundry room in the basement with the laundry staff able to describe a clean and dirty area. Residents and family members stated that the laundry was well managed.  There were cleaners on site during the day seven days a week. Cleaning was monitored by the managers and registered nurses.  Chemicals and cleaning cupboards were locked when staff were not present. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan was confirmed as being approved by the New Zealand Fire Service on 24 July 2006. There had been no building reconfigurations since this date. An evacuation policy on emergency and security situations was in place. A fire drill took place six-monthly with the last drill conducted in January 2015 and training in November around disasters. Staff confirmed their awareness of emergency procedures.  There was always at least one staff member on duty with a first aid certificate – confirmed through review of the roster.  All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.  A civil defence plan was in place. There were adequate supplies in the event of a civil defence emergency including food, water, blankets and alternative cooking arrangements.  An electronic call bell system was in place with residents confirming that staff were prompt in answering these. There were call bells in all residents’ rooms, residents’ toilets, and communal areas including the hallways, dining room and lounge areas.  The doors were locked in the evening. Systems were in place to ensure the facility was secure and safe for the residents and staff. External lighting was adequate for safety and security.  The service had had a power outage in 2014 which lasted for two days. All equipment required was in place and the nurse manager had documented a report with learnings included. The service is to purchase a generator as a result of the disaster.  A boiler was used and was serviced annually by an external provider. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There were procedures to ensure the service was responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents were provided with adequate natural light, safe ventilation, and an environment that was maintained at a safe and comfortable temperature. There was a designated external smoking area.  Family and residents interviewed confirmed the facilities were maintained at an appropriate temperature in all areas. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme was appropriate for the size and nature of the service to ensure safety for residents, family and staff. Infection control policies and procedures documented the responsibility for infection control. The designated infection control nurse was accountable to the health and safety team and to the nurse manager.  Reporting lines were confirmed in interviews with staff. The infection control nurse reported to the nurse manager any significant issues and to the health and safety team on a monthly basis. A monthly risk report was documented including key performance indicators. This provided a baseline for infection type and rate. The care givers interviewed were well informed on the processes to follow to report infections. A resident and staff infection incident register was maintained.  The infection control programme was reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control programme was implemented and provided education on infection control issues for staff and residents. The infection control co-ordinator is a registered nurse and confirmed that expertise advice can be readily sought. Appropriate resources were available and provided for the infection control nurse to perform the role effectively.  The infection control team were responsible for reviewing and developing policies and procedures when necessary and consultation was sought if required. Infection control was included in the staff induction/orientation programme. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Policies and procedures evidenced current accepted good practice and met compliance requirements. Policies and procedures sighted were comprehensive and covered relevant information to guide staff on all aspects for the prevention and control of infection. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | On-going training was provided to all staff and residents. This was evident in training records and resident meeting minutes. The infection control co-ordinator and the nurse manager were qualified and understood the principles of infection control. Both had attended education on infection control. This was evident in their training records. The nurse manager had a relevant post graduate certificate in infection control.  All newly employed staff received education on infection control as part of the orientation process. This was confirmed on the orientation checklist and evident in the individual staff records. On-going education was evident in the education programme. Attendance at in-service training for all staff was documented. |
| 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 service conducted monthly surveillance for infections. The service used standardised definitions of infections that are appropriate to the long term care setting.  The infection and surveillance data for September 2014 recorded an increase in urinary tract infections. The analysis report showed that one resident was treated on three occasions in that month for a urine infection. The staff meeting minutes recorded the actions implemented to reduce the infections, which included further staff and resident education, increase in fluids, hand hygiene and informal education with the resident. The number of urine infections was reduced to one infection the following month.  The infection control surveillance programme was appropriate for the facility and the level of care provided. Infections and the use of antibiotics were monitored and collated reports and trends were reported at staff meetings. The infection control nurse checked that infections met standard definitions. Infection rates were compared with other similar facilities for benchmarking purposes. Monthly infection summary forms were sampled and confirmed that infection rates were within nationally acceptable levels. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint minimisation was promoted by management. The restraint minimisation and safe practice policy was sighted. Definitions of enablers and restraints were correct, including the voluntary use of enablers. On the day of the audit, there were three residents with an approved restraint (bed rails) and three residents with an approved enabler. In interview, the nurse manager reported that alternatives to restraint were considered where possible. Discussions regarding risk, alternatives and approvals were sighted in records sampled. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | PA Low | Restraint procedures defined the approval process. Approval for the use of a restraint was that of the GP and the registered nurse. Approval forms were sighted in residents’ records. Restraint consent forms were also signed by the GP, registered nurse and the resident (where able) or family member.  Care staff interviewed were unclear regarding the use, and definitions, of restraint and enablers. An improvement is required. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented. The assessment process identified the underlying cause, history of restraint use, alternatives and associated risks. The desired outcome was to ensure the residents’ safety and security. Assessments were sighted in the records of residents who had a restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Monitoring requirements were implemented as defined within policy and the lifestyle care plan. Care plans for restraint identified safety needs. This included two hourly checks on any resident who had a bed rail in place. Monitoring records were maintained and reviewed by the registered nurse to ensure on-going safety. All bed rails had the required covers to minimise risk to the resident. Individual response to restraint use was included in the six three monthly nurse review, six monthly care reviews and the bi-annual quality review of restraint use. There had been no adverse events regarding restraints. The restraint register was current. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The individual use of restraints was reviewed during care plan reviews. This was evident in resident files sampled. Family members interviewed confirmed their involvement in the review process. Reviews sampled met requirements of the evaluation process. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | In interview, the nurse manager described the process of quality reviews for restraint. This included a bi-annual internal audit. Records of quality reviews were for 2014 were sighted. These met the requirements of this standard. The use of individual restraint use was also included in the regular registered nurses meetings. Records of meetings were sighted. |

# 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 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs. | PA Low | A Maori health plan was documented. There were two Maori residents and one file was reviewed. Cultural identify was documented in the InterRAI assessment and social profiles. | There was no documentation of review of the Maori health plan. ii) Cultural and spiritual needs had not been documented in the care plan of one Maori resident. | Review the Maori health plan at regular intervals. Ii) Document cultural and spiritual needs for Maori residents.  180 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Residents signed an admission agreement on entry to the service. This provided clear information around what it paid for by the service and what was paid for by the resident. All were signed on the day of admission. The same contract was used for private and subsidized residents. | The signed page only was in the resident file and this did not link to the contract document and new signing page that had been updated with the change of ownership. The agreements were in the name of the previous owner. | Include the contract and the signature page in the resident file. Ii) Update all agreements so that they are in the name of the current owner.  90 days |
| Criterion 2.2.1.1  The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. | PA Low | Training on restraint and enablers is provided and training records were sighted, however, during interview, care staff were unable to competently describe the difference between a restraint and an enabler, including their application in individual circumstances. | Staff competency regarding the correct application of a restraint, and an enabler, was not evident during staff interviews. | Provide evidence that staff are competent regarding the correct use of restraints and enablers.  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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End of the report.