# The Rest Homes Limited

## 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 HealthShare 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:** The Rest Homes Limited

**Premises audited:** Makoha Rest Home

**Services audited:** Residential disability services - Intellectual; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory

**Dates of audit:** Start date: 20 January 2015 End date: 21 January 2015

**Proposed changes to current services (if any):** Addition of Hospital - Medical service

**Total beds occupied across all premises included in the audit on the first day of the audit:** 18

# 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

Makoha Rest Home is privately owned and operated. The service provides rest home and hospital level of care for up to 36 aged and younger residents. There were 18 residents at the time of audit, 17 at rest home level of care and one at hospital level of care. Five residents were under the age of 65.

A full certification audit against the Health and Disability Services Standards and the services’ contract with the District Health Board. The audit process included an offsite review of the organisational polices and the onsite audit included the review of documentation, observations and interviews. The documentation review included a selected number of rest home and hospital residents’ files. Interviews were conducted with the owner, management, staff, residents, family/whanau and general practitioners to verify the documented evidence. The audit report is an evaluation of the combined evidence on how the service meets each of the standards.

There were three required improvements identified at this audit. All the areas are related to documentation. The service had commenced the implementation of addressing these issues at the time of audit.

The strengths of the service include how the service provided flexible and individualised care to the younger and older residents.

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

The residents and family/whanāu reported that the complaints system is easy to access and any complaints made are followed up in a timely manner. The complaints management system complied with legislative time frames. Communication processes were documented and met the needs of residents. Resident’s reported they had been informed of their rights, and open disclosure procedures ensured that communication was maintained in an open and transparent manner. Communication with residents and family about adverse events and other matters were documented. Family/whanau confirmed good communication between management, carers, family/whanau and residents.

## 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 residents receive safe services that are managed, planned and coordinated to meet the needs of the residents at hospital or rest home level of care. Recent changes in management and governance are enhancing resident and family/whanāu satisfaction with care and service delivery.

Quality and risk management systems were effective and integrated across all areas of service delivery. The service was managing all health and safety and risk matters in accordance with known safe best practice and legislation. The event reporting system was well established, effective and implemented by staff.

Recruitment, selection and management of staff met the requirements of the standards and New Zealand legislation. All staff had attended regular ongoing education and training in subject areas that are specific to the residents being cared for. There were sufficient numbers of suitably qualified and experienced staff on site 24 hours a day seven days a week. There had been an increase in the registered nursing staff with the recent introduction of hospital level of care.

## Continuum of service delivery

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

Competent and suitably qualified staff provided care and support. Service delivery timeframes were met and included input from allied health professionals, residents and family/whanau. Nursing interventions were consistent with good practice and care plans utilised well with desired outcomes evaluated. Residents and family/whanau reported they were involved in the assessment and planning process, and a range of appropriate activities were provided. Participation in activities was voluntary, and residents were able to enter and exit the facility freely with support from staff, to pursue outside activities.

Medication administration was completed by staff who had been assessed as being competent to do so, however, there was a requirement that indications for the use of ‘as required’ medications be clearly documented.

Food and nutritional needs of residents were assessed. Special needs were catered for and monitored. Food services 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. |

The facility has a current building warrant of fitness and approved fire evacuation plan. All building regulations, fire safety, emergency and security standards were met. The facility has been significantly refurbished and renovated under the current ownership. All rooms are single occupancy, with the majority of rooms having access to shared or single ensuites. There was an automated system to ensure privacy in the shared ensuites.

Cleaning and laundry services were conducted by the caregiving staff and provided to an acceptable standard. Chemicals were stored appropriately. Emergency and disaster planning was evident and equipment and resources were available on site and maintained. The service has internal heating and cooling. There is access to external gardens and verandas. Residents and family/whanau reported high satisfaction with the environment that is age and culturally appropriate.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The service was actively minimising the use of restraint. Restraints and enablers were only used to prevent harm and promote independent mobilisation. The service had clear policy, procedures and forms which met the requirements of the restraint minimisation and safe practice standard. There is an improvement required in the consistent documentation and implementation of the restraint processes.

The service implements alternatives, where possible, to minimise the use of restraints (bed rails and lap belts). Staff training in safe use of restraint occurred as part of the ongoing education programme. The restraint committee reviewed residents at least three monthly. Monitoring and review of restraint interventions occurred at an appropriate frequency to determine whether there was an ongoing need for the restraint methods in place.

## Infection prevention and control

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

There was an infection prevention and control programme suitable for identification and surveillance of infections. Infection rates, types of infections and the use of antibiotics were monitored, recorded and communicated to staff and residents.

## 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 | Staff training records showed education had been provided to care staff by a health and disability consumer advocate and an education calendar sighted indicated this was a twice yearly occurrence. Residents and family members interviewed confirmed services were delivered in accordance with consumer rights legislation. Policy described staff involvement in the consent 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 | Resident files sampled confirmed that informed consent was gained and advanced directives signed by residents were documented. Residents and family/whanau interviewed reported they were fully involved during all stages of service delivery. Two general practitioners interviewed confirmed their involvement in the consent process for specific procedures and signed documents held on resident files verified discussion held. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Health and Disability Advocacy Service information was clearly displayed. Free Wi-Fi and a residents’ phone was accessible. Minutes of a residents meeting showed an advocate had provided education and a resident interviewed demonstrated an understanding of how to access advice. |
| 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 | Family and friends of residents’ were observed visiting on day of audit, and interview with family confirmed residents were supported to maintain links. Resident files and activity records sighted included a record of community involvement and visitors. Residents interviewed reported they were able to maintain external interests, for example, a resident was supported to attend a specialised exercise programme. The facility had a van to transport residents, and some residents used mobility scooters or motorised wheelchairs. There was space to park scooters, and well maintained ramps and exits ensured residents had easy access. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service had an up-to-date complaints register which identified the date of the complaint, the complainant, description of the issue and the actions taken. The complaints sampled for 2014 indicate that complaints were investigated within the time frames of Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). There were no outstanding complaints regarding the service at the time of audit.  Residents and family/whanau interviewed confirmed they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. Staff were aware of their responsibility to record and report any complaints they may receive. One family member reported that they have made complaints in the past and have been highly satisfied with the quick response, communication and actions taken by the service. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) information was clearly displayed and written information was accessible in the facility. Resident’s interviewed report staff provided consumer rights information on entry to the service, and family confirmed they were aware of the complaints process. Minutes of resident meetings sighted indicated an advocate had been involved in providing education to residents. |
| 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 | Residents and family members interviewed reported staff treated them with respect, maintained privacy and felt safe. Admission assessments sighted included resident preferred names. Resident bedrooms and bathroom facilities were private and staff were observed knocking prior to entering. A small second lounge was available for use by residents and family/whanau, and residents who mobilised with equipment were observed to freely move from one area of the facility to another independently as able. |
| 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. | FA | Two resident files reviewed indicated the resident had identified themselves as Maori. As per policy, an assessment plan for Maori residents had been completed and te taha wairua (spiritual), te taha hinengaro (mental), te taha tinana (physical), te taha whatunanawa (well-being) needs identified and documented in the care planning process. Documentation had been signed by the resident to verify involvement in the assessment process.  Staff interviewed confirmed the facility utilised the services of a cultural advisor. Staff education records showed tikanga and cultural awareness education had been provided. A Maori health care policy was sighted. |
| 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 | Clinical files sampled included assessments which described individual culture, values and beliefs. Identified needs were included in care plans and resident interview confirmed staff followed the prescribed plan of care. Staff interviewed, reported input from a minister who was available weekly and as requested by individuals. Individual activity records were maintained and included spiritual and cultural needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A policy around discrimination was available. Files sampled included verification of individuals’ Power of Attorney with communication clearly documented. Family/whanau interviewed confirmed they were contacted as soon as possible regarding any resident needs and there was a high level of satisfaction expressed. Resident’s interviewed confirmed they felt safe in the environment. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Staff interviewed confirm they were well supported to provide the desired standard of care. For example, a new resident with an indwelling urinary catheter had required extra support and staff were provided with the appropriate education to ensure needs were met immediately. The resident confirmed that needs were met in a timely manner. Nursing procedure manuals were easily accessible to staff, and files sampled included care plans which aligned with current good practice. An education calendar was sighted, and training records confirmed education had been provided to staff. Family/whanau and general practitioners interviewed reported a satisfactory level of care was provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Written information was available and easily accessible to residents. The open disclosure policy identified that frank discussions with residents and their support person/family was required. There was evidence in records of adverse events, residents’ files and resident meeting minutes that open communication was occurring. Family members confirmed they were kept informed of all relevant issues. Records of contact with family were maintained.  Residents were able to identify staff involved in their care. Staff were identified by a name badge and uniform. |
| 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 vision, mission and values were clearly described in policy and displayed throughout the service. These are last reviewed in August 2014 as part of the business plan. There is at least weekly informal discussions with the manager and owner on the outcomes in the business plan, as confirmed at interview with the owner. The organisation ensures services are planned, coordinated, and appropriate to the needs of the younger and older residents at rest home and hospital level of care. The service also has processes in place to meet specific needs of residents requiring additional support, such as ACC injuries and medical services. There was a resident at the time of audit receiving specialised bariatric services.  The service is managed by a suitably experienced and qualified manager with business and quality management qualifications. The roles, responsibilities and accountabilities of the business and quality manager were clearly documented in their job description. The business and quality manager is supported by an onsite clinical manager. The manager commenced their contract to the service in May 2014. Interview with the owner confirmed that the business and quality management role will continue and may have increased hours as the service moves towards increasing the hospital level of care residents. The business and quality manager is a recognised Eden Alternative associate and trainer. The business and quality manager had attended in excess of eight hours professional development related to the management of aged care services in the past 12 months. The owner reports full confidence in the management team.  The provider has requested to have Hospital – Medical services added to the schedule. The provider has appropriate clinical equipment, single room occupancy and the audit of the facility found that it was suitable for the addition of this service type to the schedule. |
| 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 takes on the role of the business and quality manager during temporary absences. The clinical manager’s job description records that their role includes filling in for the management during temporary absences. The business and quality manager and owner expressed confidence in the clinical manager to undertake the management responsibilities during temporary absences. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The business, quality risk and management plan sighted provides information on the risk management strategy of the service. It explains risk and identifies risk levels supplied to the organisation. The sighted quality improvement and risk management guidelines identify objectives and action planning and support to reach identified goals. The overall objective is to meet the needs of all the residents and enhance satisfaction with support/care services and all services they provide. The business, quality risk and management plans covered all aspects of service delivery with actions shown on how to minimise identified risks, who is responsible and the timeframe for implementation.  The policies were developed by an aged care consultant, which the business and quality manager had personalised to the organisation. The policies and procedures meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. Policies have been reviewed by business and quality manager and reflect the current organisational management and level of care. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures were accessible by staff.  Key components of service delivery were linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. The manager reported the quality improvement data, results from internal audits and areas of required improvement are reported back to them through the staff meetings and in turn reports to the owner by way of phone calls and email communication.  Corrective action plans were developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective actions are documented on the internal audit forms and document the non-conformance, proposed actions and required quality improvement recommendations. When these are implemented the corrective actions are signed off as completed. A re-audit of the issue was conducted to review if the actions implemented are affective in minimising or eliminating the area of concern.  Actual and potential risks were identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted included the identified risks, how these are monitored, if the risk is a significant risk and if the implemented actions can isolate, eliminate or minimise the risk. The hazard register is maintained for each area of the service.  The business and quality manager reported that one of the strengths of the quality and risk systems is the organisations ability to implement actions in a responsive manner. Being a small organisation they have direct communication with the owner and are able to action improvements immediately. The resident/relative satisfaction survey for 2014 records overall satisfaction with the service. Where feedback was provided on areas that could be improved, these actions were implemented and signed off as completed. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service had clearly documented and known processes for reporting, recording, investigating and reviewing adverse events. Review of incident/accident records and analysis and interview with the business and quality manager confirmed that all events were reported, recorded and reviewed by the manager, as soon as possible.  The manager understands their responsibilities for essential notification to the relevant authorities. The service has had to report an incident to the police service since the last audit. Review of the incident documentation and interview with the manager and clinical manager confirmed those investigations and corrective and remedial actions were implemented where necessary. |
| 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 | Human resources policies described good employment practices that meet the requirements of legislation. The sighted human resources practices are implemented as per policy requirements in the staff records reviewed. The staff files identified that staff were employed to undertake roles appropriate to their skills and knowledge. Documentation sighted includes referee checks and police vetting for newly appointed employees as appropriate.  Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The manager ensures staff that require practising certificates have them validated annually. Practising certificates are sighted for all staff that require them.  New staff received an orientation/induction programme that covers the essential components of the service provided. The manager reports that since the provision of hospital level of care, the service has employed a number of registered nurses. As the registered nurse role was new to the service, they are still reviewing and developing the induction programme for the nursing staff, as the service becomes more aware of the specific skills that the nurses require for the care of the current residents  The service provides regular in-service staff education which is documented and identifies that guest speakers/educators along with current RNs present education. A resource folder is kept of the content of education provided. Each staff member has a clearly identified education attendance record. Staff appraisals are up-to-date and used as a method for staff to identify educational needs, wants and interests. Education sighted covers all key components of service delivery. Caregivers are encouraged and supported to undertaken the national certificate for the older person.  The residents and family/whanau interviews and the 2014 resident/relative satisfaction survey results sighted confirm services are delivered in a manner to meet required needs. The residents and family/whanāu provided positive feedback on how the care is provided in an individualised and flexible manner that meets the resident needs, with comments provided on the cultural appropriateness of the care. The younger residents report that the provision of services and care is provided in an age appropriate manner, and they are encouraged to maintain links with community, friends and whanau. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There were clearly documented and implemented processes which determine staffing levels and skill mixes in order to provide safe service delivery and considers the layout of the service. The business and quality manager (RN) is onsite three days a week. The clinical manager (RN) works Monday to Friday. At times the managers were required to work as the on duty RN. There is an on call roster for clinical advice after hours. There is at least one RN on duty at all times. The care staffing levels for the service for the current 18 residents (17 rest home and 1 hospital level of care) meet the minimum requirements.  The caregivers assist with the cleaning and laundry duties. Two caregivers commented that at this stage they could manage the resident care and cleaning/laundry duties, but do give priority to the resident care. The manager reports that as resident numbers requiring hospital level of care increases the organisation, that the skill mix will be reviewed.  There were sufficient kitchen and activities staff to meet the needs of the residents. .  The residents and family/whanau report satisfaction with the skills of the staff and the care provided, and have high praise for the flexibility and individualised care that is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The administration information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. On admission the admission details and unique identification NHI for each resident is obtained. Information of a private or personal nature was maintained in a secure manner that is not publicly accessible or observable. The resident’s files were securely stored in a locked cabinet in the nursing station. Archived records were stored securely on site, these are retrievable as required. The archived records were stored alphabetically.  All residents’ records are legible and the name and designation of the service provider is identifiable. The service uses a mix of paper based and electronic assessment and record keeping. The service is in the process of transitioning to the electronic InterRAI assessment and the use of electronic care plans. The electronic records are password protected and secure log in is required to access resident information. All records pertaining to individual residents were integrated.  All clinical files were observed to be secured in a locked cupboard in the nurses’ station which was only accessible by staff. The files sampled included uniquely identifiable resident information. NHI numbers and relevant individual information was documented. Photo identification was utilised with documents sighted to show consent to use photo’s had been obtained. Staff clinical entries included date and time and were completed within required timeframes.  A resident register was sighted and included a record of past and present residents. |
| 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 guidelines were clearly documented in service policy, and processes were implemented to ensure residents’ entry to the service was facilitated in a competent, equitable, timely and respectful manner. Resident information packs sighted, provided on admission, ensured residents were given sufficient information. Family members interviewed confirmed they had received information packs and been fully informed during all processes. A review of clinical files confirmed the necessary needs assessments had been completed and residents placed in an appropriate level of care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Organisation policy and procedures were sighted and interview with an RN confirmed the correct processes were followed. Referral letters to other service providers were sighted on clinical files and copies of correspondence retained. One file sampled confirmed a resident who had required a higher level of care had been referred to the needs assessment service co-ordinator (NASC) for a re-assessment. This had been done in a timely manner and the resident now receives the appropriate level of care. Interview with family confirmed they had been kept fully informed during the referral process and were involved in the assessment. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There were documented policies and procedures for all stages of medication management including self-administering medications. There were no residents who currently self-administer medications.  The service safely implemented a medication system which complies with current legislative requirements and safe practice guidelines, however there was one area of improvement required which related to the documentation of ‘as required’ medications.  Staff were observed administering medications during the lunch time medication round and followed correct procedures. Administration records were maintained. Interview with staff and a review of staff files confirmed that only staff who had been assessed as competent were responsible for medication management. The medication trolley and cupboards were observed to be locked, with the keys being held by the staff member responsible for medications on that day.  Ten medication charts were sampled. All medicines had been prescribed by the GP and a pharmacy generated administration charts maintained. All charts included photo identification and any allergies identified. Three monthly GP reviews were evident. Individually prescribed medications were used and a blister pack system utilised. A controlled drug locked safe was secured and evidence of regular reconciliation being maintained. There were no documented adverse events related to medications. A medication fridge was observed to contain insulin, and daily monitoring of temperature had been recorded. The service did not use standing orders. |
| 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 | Residents were provided with a well-balanced diet which met nutritional requirements. Kitchen staff interview confirmed dietician input with the relevant report sighted and the recommended changes implemented. A four weekly menu was followed and the meal provided on the day was in line with the menu sighted. A diary was sighted and included any deviations from the menu, and any individual resident requests. Residents interviewed were extremely satisfied with the meals provided. A residents’ fridge was available in a common area with food stuffs covered and named.  The cook interviewed confirmed dietary assessments were completed on admission, and special dietary requirements were highlighted and recorded on documents held in the kitchen. Individual food preference lists were sighted and any allergies identified.  Kitchen staff had required food safety qualifications. The kitchen, pantry and refrigerator were sighted. The kitchen was well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs were stored appropriately. There was evidence of temperature monitoring and maintenance of a cleaning schedule. Labels and dates were on all containers, and food in the refrigerator was covered and dated. There had been no reported incidents of residents becoming unwell as a result of poor food handling practices. |
| 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 | An organisational policy provided guidelines around declining entry to the service. There was no evidence of potential service users being declined entry. Clinical staff interviewed were able to give reasons for declining entry and the general practitioner (GP) confirmed consumers referred to the service had not been declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents had a nursing assessment completed in files sampled. They were completed within the identified timeframes and included resident centred goals. Residents and family/whanau confirmed their involvement in the assessment process. Clinical staff demonstrated use of a variety of assessment tools to assist in the assessment process. Progress notes and interviews with clinical staff confirmed assessment was an ongoing process, with regular evaluations being completed by the RN. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long-term and short-term care plans were developed and included goals identified by the resident. Clinical staff interviewed confirmed access to resident files, and completion of daily progress notes demonstrated prescribed care was completed. There was evidence of allied health support within the care plan process, for example, physiotherapy. Residents observed had the necessary prescribed equipment to minimise risk and promote independence. Interview with the GP described an effective working relationship with staff, and confirmed continuity of service delivery. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The RN, GP and care staff were interviewed regarding prescribed care and care plans were sighted. Interventions were consistent with best practice. Short term care plans were developed as required, for example, for one resident who recently developed an infection. Documentation completed daily by care staff confirmed care was being completed as prescribed. Observation of clinical staff handover demonstrated that staff discussed the needs of individual residents on a daily basis. The GP had confidence that interventions were implemented in an appropriate and timely manner. |
| 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 activities co-ordinator was interviewed. Activities were facilitated five days per week. Activities were planned one month in advance and included a variety of activities appropriate to resident needs, which includes specific activities for the younger residents with physical disabilities. There was a strong emphasis on linking with community, family/whanau and culturally appropriate activities. Support was provided for individuals to attend activities specific to their needs, and included transport and one on one support as required. Residents were observed participating in the days planned activity, they were well supported and appeared to be enjoying the activity. Participation records were maintained and interviews with residents confirmed participation was voluntary and they were satisfied with the activity programme. An activities board was visible in a common area and included upcoming events and photos of previous events. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Organisation policy described an evaluation process. Files sampled included evaluations which were documented according to policy, they were conducted regularly and described degree of achievement and progress towards meeting desired outcomes. The RN described the process, and evaluations showed clear links to the care plan. The RN initiated changes to the plan of care where progress was different from expected, for example, short term wound care plans. Interview with two family members confirmed a high level of satisfaction with the service supporting the resident to achieve their desired outcome. |
| 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 | Interviews with clinical staff, GP’s and family members confirmed residents were provided with access to other service providers as required. Files sampled demonstrated links via a referral process with allied health professionals, for example, physiotherapy, wheelchair specialists, speech therapy and acute care hospitals. Progress notes sighted included entries made by allied health staff. Care plans had been adapted as necessary to include specialist care and advice. Family/whanau interviewed stated they had been kept fully informed during the referral process. |
| 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 | There were adequate polices for the management of waste and hazardous substances. The chemicals were observed to be securely stored in the laundry and sluice rooms. The laundry and cleaning was conducted by the caregiving staff. The staff who participate in the laundry and cleaning reported that they follow the documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances. There was appropriate personal protective equipment and clothing in the laundry, and sluice rooms. Education for the handling of waste or hazardous substances was conducted by the external chemical provider, as part of in-service education programme. |
| 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 warrant of fitness expires May 2015.  Equipment was maintained to ensure safety. Electrical tag and testing was last conducted in January 2015. The calibration of the medical equipment was last conducted in September 2014. It was noted that there was one standing hoist due for an electric safety test. The manager addressed this at the time of audit.  In the past two years there has been a renovation and refurbishment plan, with all areas sighted being in a good state of repair. The service had a planned and reactionary maintenance programme, with the building maintained in an adequate condition to meet the needs of the residents. The maintenance log notes area of work required and is signed off when the work is completed.  The fittings and furniture installed are maintained to ensure safety and the needs of the residents. The furniture cleaning is part of the planned maintenance and cleaning programme. The physical environment is appropriate for the older and younger residents. There is disability access at the front and rear entrances. The residents’ rooms sighted were personalised with the resident’s possessions. The facility had safe and accessible external areas that meets the resident’s needs.  Hot water temperatures in resident areas were monitored monthly. The temperatures sighted were within the safe temperature guidelines for aged care. |
| 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 24 rooms that have access to single or shared ensuite, shower, toilet and hand basin. Where there is shared access to the ensuites there was an automated privacy locking system to ensure the resident in the adjoining room cannot access the bathroom when the other resident is in the ensuite. There were additional shared toilet/shower/bathing facilities that are conveniently located throughout the service for the rooms that do not have ensuites. |
| 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 | All rooms are single occupancy. All rooms sighted are of a suitable size for the needs of the resident. A room sighted was fitted with specialised bariatric equipment and ceiling hoist. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. Residents who use mobility aids were able to safely manoeuvre with the assistance of their aid within their room. The residents and family/whanau interviewed report satisfaction with their rooms and all stated that they appreciated the size of the rooms. |
| 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 | There were lounge areas throughout the facility in both the rest home and hospital wings of the service. There was an opened planned dining and entertainment area which is separated by the layout of the furniture. The lounge and dining areas are separated and activities in these areas do not impact on each other. The service had a lounge/whanāu room for smaller or family groups. The resident rooms also have facilities for family/whanau if the resident wished to entertain in their room. The residents and family/whanau interviewed report satisfaction with the lounge and dining facilities. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The care staff conducted the cleaning and laundry roles. The laundry had a dirty to clean flow. The effectiveness of the cleaning and laundry processes were reviewed as part of the internal audits and safety inspections. The washing machines had automated systems for ensuring that the appropriate temperature is reached for each type of wash. The caregivers interviewed who assist with laundry and cleaning services reported they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The care staff reported that they currently have adequate time to do the cleaning and laundry, with priority given to resident care.  The laundry and cleaning equipment was observed to be stored in safe and hygienic areas. The resident and relative satisfaction survey conducted in 2014 records overall satisfaction with the cleaning of the facility. The residents and family/whanau reported satisfaction with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Approved evacuation scheme was date 19 January 2015. The service conducts six monthly evacuation training.  The service had adequate emergency supplies in the event of an emergency or outbreak. There were stored supplies of food and water for at least three days. There is a civil defence kit with additional food, first aid and emergency supplies. In the case of mains failure, the service had access to emergency lighting and torches.  All resident rooms, bathrooms and lounge areas have a call bell system installed. The call bell system has an audible alert, a light that comes on above the door and panels in the staff office. The residents and family/whanau reported that the call bell is answered in a timely manner.  The orientation and ongoing training records sighted evidenced that staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. There is at least one staff member on duty that has current first aid qualifications.  The service identified and implemented appropriate security arrangements relevant to the residents at rest home and hospital level of care. The afternoon staff are required to close and lock the external windows and doors before it gets dark. There are external and internal security cameras in communal areas and the kitchen for asset tracking and monitoring of unauthorised access to the service. There are appropriate systems in place for monitoring, access and ensuring resident privacy. The residents and family/whanau reported they feel safe and secure at night. |
| 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 | Areas used by residents and staff were ventilated, heated and cooled appropriately. The service had a combination of air-conditioning and heat pumps to provide heating and cooling in resident areas. All resident-designated rooms (personal/living areas) had at least one external window of normal proportions to provide natural light and ventilation. The residents and family/whanau reported satisfaction with the natural light, ventilation and heating. |
| 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. | PA Low | The designated infection control co-ordinator was interviewed and confirmed a surveillance programme was maintained. Surveillance data was sighted and included infection details related to clinical files sampled. Monthly analysis was completed and reported at monthly general staff meetings. Education had been provided by a pharmacist. Minutes and training records were sighted. A review of the orientation programme confirmed new employees receive education related to infection control and hand washing. Staff observed during the audit used personal protective equipment appropriately. There had been no outbreaks of infection.  The organisation had clearly defined policies and procedures, however the programme had not been reviewed annually as described in policy.  An Interview with the GP and a review of clinical files and medication charts showed antibiotics were prescribed only if clinically indicated. |
| 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 | Staff observed during the audit completed hand hygiene and used personal protective equipment appropriately.  Hand sanitizer was readily available to residents, staff and visitors with hand washing posters visible. Staff were able to identify infection control team personnel and staff demonstrated an awareness of external resources to access as required. |
| 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 were available and the co-ordinator was able to demonstrate that available external resources were utilised to ensure current best practice. Staff confirmed they were able to access information in a timely manner to ensure safe practices were maintained. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Education had been provided to staff around infection control. The training sessions were documented and attendance records completed. Minutes of staff and resident meetings indicated infection control issues were addressed. |
| 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 infection control co-ordinator confirmed a surveillance programme was maintained. Surveillance data was sighted and included infection details related to files sampled. Monthly analysis was completed and reported at monthly general staff meetings.  The infection control surveillance is appropriate to the size of the service. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint minimisation and safe practice policies sighted meet the Standard’s requirements.  The restraint register records there were two residents requiring restraint (bed rails) and two residents with enabler use (bed rails and a chest strap). Where enablers were used these were voluntary and the least restrictive option for the safety and comfort of the resident’s. The service uses the same documentation for restraint and enabler use.  There was recorded staff training on restraint minimisation. Strategies for managing challenging behaviours, understanding delirium, confusion and dementia were in-service education topics. Though the care staff did demonstrate knowledge that enabler use was the voluntary use of restraint, they provided conflicting information from the restraint register as to what devices and residents had restraint and enabler use (refer to 2.2.1). |
| 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 | The approved restraints and enablers at the service are the use of bed rails, lap belt and a bed lever. At the time of audit bed rails were the type of restraint in use. The restraint coordinator reports that the service has reduced the use of the types of restraint for one resident, who had required a lap belt and a bed rail; this has now reduced to bedrails only.  There is a restraint committee that meets at least three monthly (minutes sighted). The restraint coordinator and restraint committee have approved all restraint use, in conjunction with the GP and nursing team. Consent from family/whanau, GP and RN is required before restraint is approved, the consent form is sighted in the two resident’s files that have restraint use.  Though the restraint approval and restraint process were documented, these are not consistently implemented and understood by staff (refer to 2.2.1.1). |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service had a restraint assessment form that included the factors of this standard. The restraint coordinator reported that restraint is only put in place following appropriate review of the risks and benefits of restraint or enabler use, such as considering the wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm and is there a balance between independence and protection. Both the residents with restraint use had a documented assessment for challenging behaviours; though the restraint risk assessment form was not evidenced in both files (refer to 2.2.1.1).  The clinical staff demonstrated, understood and implements alternatives to restraint, such as low beds and sensor mats, whenever possible. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint coordinator reported that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is to be monitored according to risk and a restraint register is maintained. Frequent falls by individual residents will often generate commencement of reviewing the need for bed rails.  Restraint was documented in the restraint register (sighted). The restraint register records the type of restraint, when approved, review dates and if the restraint is still recommended for user. All enablers and restraint are recorded on the registers and consented to by the family/whanau and the resident as appropriate. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint coordinator reported that all restraint and enabler use is evaluated at least three monthly as part of the resident review process. The evaluation process was sighted in the files of both residents with restraint use. Restraint reviews were reported and discussed at the restraint committee meetings. The evaluation process included all the points below. The resident and family/whanau consultation was included in the evaluation of both the residents with restraint use. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The monitoring form included the type of restraint, reason for use, time frames for monitoring, how long the restraint is to remain in use and a record of the checking of the resident. The file review of one resident’s monitoring form indicated two hourly monitoring of the resident when the bed rail is up, though the monitoring form only records when the bed rail went up then when it was removed, not the two hourly monitoring. The progress notes record that the resident had two hourly checks overnight.  The quality review of restraint was part of the three monthly restraint committee meeting. The service conducted an annual quality review of the restraints uses. The quality review form included the types of restraint used, the alternatives, if the restraint is used for the least restrictive and minimum amount of time, if policies and procedures are followed, impact of restraint, if the care plan provided information on the restraint use, if the consent forms and evaluation include family/whanau involvement, if staff education is required, review of the restraint registrar and any corrective actions that are required.  The restraint coordinator reported that they have been able to reduce and cease the use of a lap belt for one resident. Alternatives that are used are low beds and senor mats. The restraint use is closely linked to the falls reduction programme. All restraints are used for the safety and comfort of the resident. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Ten medication charts were sampled. Staff responsible for medication management were interviewed and were able to demonstrate and explain how do access the required information as necessary. | Medications did not include indications for use for ‘as required medication’. | Document indications for use.  90 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | Review of organisation policy described an annual review of the infection control programme, however, it had not been completed. | There was no documented evidence that there is an annual review of the infection control programme. | Provide documented evidence that the infection control programme is reviewed at least annually. .  180 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 | The responsibility for restraint process and approval was defined and documented in the restraint minimisation policies and procedures. The documented process included assessment, consent, care planning, review, monitoring and evaluation. The process for the implementation of restraint assessment, care planning and monitoring were not sighted in the files of the two residents with restraint use (bed rails). One of the residents with restraint use had a different type of restraint recorded in the care plan to what was currently used. The other resident with restraint use did not have the type of restraint recorded in their care plan. Both the care plans were updated at the time of audit. The care staff did not have a clear understanding of the use of the monitoring forms. | The process and documentation for the restraint assessment, monitoring and care plan are not fully evidenced or accurate for the two residents with restraint use. | Ensure the process and understanding of the restraint processes are implemented, documented and understood by staff.  180 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.