# New Aged Care 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:** New Aged Care Limited

**Premises audited:** Glenhaven Resthome

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 4 May 2015 End date: 5 May 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:** 17

# 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

Glenhaven Rest Home is a family owned service that provides rest home level of care.

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

The clinical nurse manager and management team are appropriately qualified and experienced for the roles they undertake. The strengths of the organisation is their smaller size, homelike environment and the team approach to resident care.

There is one area for improvement related to the documentation in the medication management system.

## 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. |

Staff demonstrated good knowledge and practice related to respecting residents’ rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

Residents from a range of cultures, including Maori, reported that their individual cultural values and beliefs were respected, and this was supported in care planning documents reviewed. The service provider reports there are no known barriers to Maori residents accessing the service.

Linkages with family and the community are encouraged and maintained. The service is located close to community facilities which residents can access as appropriate.

The service has a documented complaints management system implemented. There were no outstanding complaints at the time of audit.

## 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 organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents’ needs. The management team regularly review the business, risk and quality plans.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system included an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff. Reporting processes include external benchmarking so data can easily be compared to previously collected data and other aged care services.

The day to day operation of the facility is undertaken by staff who are appropriately experienced, educated and qualified. This allows residents' needs to be met in an effective, efficient and timely manner.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

There was no information of a private nature on public display. The resident’s records are securely maintained.

## 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. |

The services policies and procedures provide guidelines for access to service. Timeframes for service delivery are met and include input from residents, families, and allied health professionals. Initial assessment, care and support is provided by competent staff, with ongoing evaluations completed by a registered nurse. Nursing interventions are consistent with best practice and care plans well utilised.

There is a broad range of activities which are appropriate for the service users. Residents and families interviewed confirm they are well supported to maintain interests and participation is voluntary.

The service has a documented medication management system. An improvement is required to ‘as required’ medications having documented indications for use and ensuring there is a reconciliation process for medications received into the facility.

Nutritional needs are met. Special dietary requirements are catered for and regular monitoring completed. Food services and storage meet 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. |

There are documented emergency management response processes which were understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness. There is an approved evacuation scheme and ongoing maintenance plans. The building is suitable for the needs of rest home level of care residents. There are appropriate cleaning and laundry services.

The facilities meet residents’ needs and provide furnishings and equipment that is regularly maintained. There are adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs.

The building is suitably heated, cooled and ventilated. The outdoor areas and decks provide suitable furnishings and shade for residents’ use.

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

There are no restraints used in the facility. There are documented guidelines for the use of restraint, enablers and challenging behaviours. Staff receive sufficient training and demonstrate an understanding of the appropriate use of enablers to maintain independence.

## 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. |

Infection prevention and control policies and procedures are adequately documented. There is a designated infection control co-ordinator who is responsible for ensuring monthly surveillance is completed and monitoring of infection control practices. Documentation sighted provides evidence that all staff are educated as part of an initial orientation and as part of on-going in-service education

## 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 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 1 | 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 Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility and in each residents room. New residents and families are provided with copies of the Code as part of the admission process.  Staff files evidenced completed annual competencies in relation to the Code. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed respecting the residents’ rights. |
| 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 at entry to the service.  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 | The families reported that they were provided with information regarding access to advocacy services and were also encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service was listed in the resident’s information booklet, with the brochure available at the entrances to the service. Education is conducted as part of the in-service education programme. |
| 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 | There are no set visiting hours and family/whānau are encouraged to visit at any time. The family/whanau report there are no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. The facility is close to community facilities and residents report they are encouraged to access these independently as able. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents, including complaints.  Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education. This is confirmed during interview.  Residents and family/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time. The complaints register records the complaint, dates and actions take, these are addressed to comply with right 10 of the Code. There are no outstanding complaints at the time of audit.  Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The families and residents interviewed reported that the Code was explained to them on admission and was part of the admission pack and displayed in their room. Nationwide Health and Disability Advocacy service information is part of the admission pack. |
| 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 | All rooms are single occupancy at the time of audit. The service does have seven rooms that are able to be shared by couples. The residents reported they are treated with dignity, and their privacy and independence is maintained. The residents' files reviewed indicated that residents receive services that are responsive to their needs, values and beliefs. The family/whanau and general practitioner (GP) interviewed expressed no concerns with abuse or neglect. The family/whanau and residents interviewed reported high satisfaction with the way that the service provided care. |
| 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 | Residents who identified as Maori reported satisfaction with the cultural appropriateness of the care and services. The file of a Maori resident had a specific care plan for their cultural needs. The manager reported that there are no barriers to Maori accessing the service. The caregivers interviewed demonstrated good understanding of services that meet the needs of the Maori residents and importance of whanau. |
| 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 residents' files demonstrated consultation with families on the resident's individual values and beliefs. The residents and families reported they were consulted with the assessment and care plan development. Staff education has been conducted on the aging process and spiritualty by an external provider. The caregivers interviewed demonstrated good knowledge on respecting resident’s culture, values and beliefs. The cultural needs of a resident who is from a different culture had their specific needs recorded. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff files reviewed had job descriptions, employment agreements and staff handbooks that had clear guidelines regarding professional boundaries and house rules. Families and residents reported they are satisfied with the care provided. The families expressed no concerns with breaches in professional boundaries, discrimination or harassment. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. There is a training programme implemented. Staff interviewed described sound practice based on policies and procedures, care plans and information given to them via the registered nurse.  Quality initiatives are undertaken to improve the lives of residents, and staff are able to describe how these have benefitted residents, for example reducing falls.  All residents and families interviewed express a high level of satisfaction with the care delivered. All stated that they have no intention of complaining as the service is excellent.  Consultation to other services is available as required. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures are in place for accessing interpreter services. The families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented on the accident/incident form and in the residents' progress notes. |
| 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 service provides rest home level of care under the aged care contract with Waitemata DHB. The service has 18 rooms, some of these can be double rooms to provide a maximum capacity of 24 residents. The service tends to use the double rooms as single rooms (unless required for couples) and operates mostly with 18 residents. At the time of audit there were 17 residents.  The services is owned and operated as a family business. Strategic planning is identified in the 2015 strategic plan. It covers all aspects of service delivery to meet the needs of rest home residents. The vision and mission statements of the organisation are documented and reviewed annually as part of the business planning process. Risk management is included in the business planning process and is monitored three monthly through the management and service review meetings. The owner and manager have the overall role of the governance and strategic direction.  There is a clinical nurse manager who covers the clinical aspects of the service delivery. The clinical nurse manager is a registered nurse (RN) with a current practicing certificate. Job descriptions identify management staff’s experience, education, authority, accountability and responsibility for the provision of services. The manager reports confidence in the clinical nurse manager to undertake the clinical management role. The clinical manager has input into the strategic and quality planning. The clinical nurse manager also has support from a clinical advisor, who does site visits at least three monthly and takes on role of clinical manager as required. The clinical nurse manager has been in the role since February 2015, with ongoing education planned to ensure they have at least 8 hours of education related to the management of aged care services. The service is a member of aged care associations, with these providing ongoing education related to management.  Service satisfaction was reported during resident and family/whānau interviews and by the results sighted for the 2015 resident and family/whānau satisfaction surveys. |
| 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 | There is a clinical advisor who undertakes the clinical manager role during temporary absences. The manager reports that the clinical advisor has extensive experience in aged care and they are confident in their ability to perform the clinical manager role during temporary absences. Their annual practicing certificate 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 | The service has a quality and risk management system which is understood and implemented by the staff. There is a quality plan and a risk management plan. These include the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. All reporting is linked to monthly benchmarking with an external aged care consultancy agency. This information is used to inform ongoing planning of services to ensure resident needs are met.  Policies and procedures were developed by an aged care consultancy agency. These are personalised to the service by the manager. The policies have been updated at least two yearly, or sooner if there was a change in legislation or best practice. There are appropriate systems in place for the control of documents to ensure staff only have access to the current version.  The quality improvement data is collected, analysed and benchmarked. The internal auditing plan covers all aspects of services delivery including resident care planning, the environment, infection control, resident and relative satisfaction. The internal audits sampled evidence corrective planning to address any shortfalls. Feedback is provided to the appropriate levels of staff, for example food services to the cook, clinical audit outcomes to the caregiving staff.  The service also have quality improvement forms based on suggestions from staff, residents and visitors for areas that can be improved on. The forms sampled record the improvement implemented and follow up of the evaluation the effectiveness of the improvement.  Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.  Actual and potential risks were identified and documented in the hazard register. There were interventions implemented to either eliminate, isolate or minimise the hazards. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. |
| 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 | Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified. Actions to be taken are clearly set out in graph form for staff to follow.  Management understood their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. There have been no incidents that have required essential notification. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required.  Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Falls management strategies are implemented for residents who have falls. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.  Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles, which are repeated annually, as confirmed in five of the six staff files. The remaining file did not have a copy of the orientation and induction training, though the staff member, manager and assistant manager confirm that the clinical advisor had completed this with the staff member.  Staff undertake training and education related to their appointed roles. Staff education includes the training programme developed by the aged care consultant. The education programme covers the contractual requirements of the aging process. There is also education, training and clinical mentoring provided through external providers and the DHB specialists. Education records were sighted in the staff files and the training records. The service also has access to specialist aged care online training.  Residents and families interviewed, along with the resident and relatives satisfaction survey results, identified that residents’ needs are met by the service. No negative comments were voiced during interviews on the days of audit. Residents and families reporting that the homelike, personalised and team approach to care is a strength of the service. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. The staffing and skills mix comply with the funders contractual requirements for rest home level of care. The service operates on a ‘master roster’ where each staff member is allocated set shifts.  The assistant manager and owner/manager reported that additional staff would be rostered to meet residents’ needs and this was confirmed by staff interviewed. Required staffing levels and skill mix is clearly documented to meet contractual requirements.  A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs. Residents interviewed stated all their needs have been met in a timely manner. All staff have current first aid qualifications.  The activities coordinator works Monday to Friday and there are appropriate levels of kitchen, cleaning and maintenance staff. In addition to the rostered staff the owner/managers are onsite five days a week, with one of the owners assisting with the activities programme. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Information is entered into the resident information management system in an accurate and timely manner. Records were securely stored. Archived records were stored onsite. When required, records were appropriately destroyed.  Progress note entries are made at least daily. These records were legible and the name and designation of the staff member documented on most occasions. There were some entries that did not have the designation of the staff member, this was addressed on the day of audit and is not reflective of a systemic issue. There was also a signature register to assist with the identification of staff entries.  All records pertaining to individual residents were integrated. Information of a private or personal nature is maintained in a secure manner and was not publicly accessible or observable at the time of audit. |
| 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 are clearly documented in service policy, and processes are implemented to ensure residents’ entry to the service is facilitated in a competent, equitable, timely and respectful manner. Resident information packs sighted, provided on admission, ensure residents are given sufficient information. Family members interviewed confirm they had received information packs and have been fully informed during all processes.  A review of clinical files confirm the necessary needs assessments have been completed and residents placed in an appropriate level of care. Signed and dated admission agreements are sighted and staff interview verifies the processes which ensures residents receive the necessary prescribed care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy and procedures, and the RN confirms the correct processes are followed around exit and discharge. Referral information provided to other service providers is sighted on clinical files and copies of correspondence retained.  One file sampled confirms a resident who has required a higher level of care has been referred to the needs assessment service co-ordinator (NASC) for a re-assessment. This has been done in a timely manner and the resident now receives the appropriate level of care. |
| 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 are documented policies and procedures for medication management, however, there is no process which involves the registered nurse (RN) checking medications as they are received into the facility.  Staff are observed administering medications during the lunch time medication round and follow correct procedures. Administration records are maintained. Interviews with staff and a review of staff files confirms that only staff who have been assessed as competent are responsible for medication management. Medication trolleys and cupboards are observed to be locked, with the keys being held by the staff member responsible for medications on the day.  Medicines have been prescribed by the GP using a pharmacy generated medication chart. All charts include photo identification and any allergies identified. Three monthly GP reviews are evident. Individually prescribed medications are used and a robotics pack system utilised.  There is one controlled drug locked safe and controlled drug logs are maintained with evidence of regular reconciliation sighted.  Two medication files sampled include residents who self-administer medication. Residents have been assessed as competent to self-administer medications and the relevant form confirming this is signed by both the resident and the RN. A medication fridge is observed and daily monitoring of temperature is completed.  Residents are prescribed medication that could be used as required however indications for use are not consistently documented.  There have been no adverse events related to medication management. |
| 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 are provided with a well-balanced diet which meets nutritional requirements. Kitchen staff confirm that there is dietitian input into the menu and the relevant report confirming this is sighted. A four weekly menu is followed and the meals provided on the day are in line with the menu sighted. Residents interviewed are satisfied with the meals provided.  Dietary assessments are completed on admission and special dietary requirements are highlighted and recorded on documents held in the kitchen. Individual food preference lists are sighted and any allergies identified. Special equipment is available as required, for example, one clinical file sampled makes reference to the use of a rim plate and use was observed during meal time.  Kitchen staff have required food safety qualifications.  The kitchen is well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs are stored appropriately.  There is evidence of temperature monitoring and maintenance of a cleaning schedule.  Labels and dates are on all containers, and food in the chiller is covered and dated. There have 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 | Organisational policies provide guidelines around declining entry to the service. There is no evidence of potential residents being declined entry. Clinical staff interviewed are able to give reasons for declining entry and the general practitioner (GP) confirms residents referred to the service have 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 have a nursing assessment completed. They are completed within the identified timeframes and include resident centred goals.  Residents and families interviewed confirm their involvement in the assessment process.  Clinical staff demonstrate use of a variety of assessment tools to assist in the assessment process.  Progress notes and interviews with clinical staff confirm that assessment is an ongoing process with regular evaluations being completed by the registered nurse (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 are developed and include goals identified by the resident.  Clinical staff interviewed confirm access to resident files and completion of daily progress notes demonstrate prescribed care is completed.  There is evidence of allied health support within the care plan process, for example, physiotherapy.  Residents observed have the necessary prescribed equipment to minimise risk and promote independence. The GP describes an effective working relationship with staff, and confirms 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, general practitioner (GP) and care staff are interviewed regarding prescribed care and care plans are sighted. Interventions are consistent with best practice. Short term care plans are developed as required, for example, for one resident who recently developed an infection.  Documentation completed daily by care staff confirms care is being completed as prescribed.  Observation of clinical staff handover demonstrates that staff discuss the needs of individual residents on a daily basis. The GP has confidence that interventions are 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 is interviewed. Activities are facilitated five days per week. Activities are planned one month in advance and include a variety of activities appropriate to resident needs.  Support is provided for individuals to attend activities specific to their needs, and includes transport and one to one support. Residents are observed participating in the days planned activity, they are well supported and appear to be enjoying the activity.  Participation records are maintained and residents confirm participation is voluntary and they are satisfied with the activity programme. An activities board is visible in a common area and includes 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 | A policy describes an evaluation process. Files sampled include evaluations which are documented according to policy, they are conducted regularly and describes the degree of achievement and progress towards meeting desired outcomes. The RN described the process, and evaluations sighted show clear links to the care plan.  The RN initiates changes to the plan of care where progress is different from expected, for example, short term wound care plans.  Family members confirm 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 and family members confirm that residents are provided with access to other service providers as required.  Files demonstrate links via a referral process with external health professionals, for example, acute care hospitals, wound care specialist. Care plans have been adapted as necessary to include specialist care and advice. Families state they have 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 | Chemicals are stored securely. With the exception of one bottle of chemicals, which had a label placed on it on the day of audit. Chemicals are clearly labelled and safety data sheets are available. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons appropriately. The cleaner demonstrated knowledge of handling waste and chemicals. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in February 2016. There is an annual safety inspection for the lift.  Maintenance is undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurs annually and was completed in September 2014 by a registered electrician. All electrical equipment sighted had an approved testing tag. Clinical equipment is tested and calibrated by an approved provider at least annually.  The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. There are stairs and a lift to the upper floor. Regular environmental audits sighted identify that the service actively strives to maintain a safe environment for staff and residents.  The service identifies planned annual maintenance and hazard identification forms for areas that require maintenance. There are external areas off the lounge and dining areas. The upper deck has an umbrella for shade. There is access to garden areas.  Residents and family/whānau members confirmed the environment was suitable to meet their needs. |
| 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 are adequate centrally located toilet/shower facilities for residents with separate staff and visitor facilities. The toileting facilities are located on the upper and lower levels of the service. There is one room that has an ensuite with a basin, toilet and shower. One toilet area had some minor chipping to a wall surface, this is on the maintenance plan for repair and not reflective of a systemic issue. All but one room has a hand basin in the bedroom. Hot water temperatures are monitored and documentation identifies that they remained within safe levels. |
| 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 bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. There are six rooms that have the capacity to be double rooms, the manager reports these would only be used as shared rooms for couples. All rooms at the time of audit are single occupancy. Rooms have appropriate areas for residents to place personal belongings. Resident and families members interviewed confirmed they were happy with their bedrooms and stated that lack of privacy is never an issue. |
| 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 | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Dining and lounge areas are separated. The areas are appropriately furnished to meet residents’ needs. Activities are undertaken in both the lounge and dining areas. Residents and family/whānau voiced their satisfaction with the environment. |
| 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 service has standing operating procedures in place for cleaning. There is a dedicated storage area for cleaning equipment and chemicals. The external chemical supplier provides a monthly report on the effectiveness of the cleaning and laundry equipment and chemical usage.  All laundry, including residents’ personal laundry, is undertaken onsite by the caregiving staff. During interview, residents and family/whānau confirmed they are happy with the laundry services provided. Staff interviewed confirm they always have enough linen to meet day to day needs. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider.  Emergency supplies and equipment include food and water. The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. A letter sighted from the New Zealand Fire Service (2004) confirms the approved evacuation scheme. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.  Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking (sighted).  Emergency education and training for staff includes six monthly trial evacuations.  Appropriate security systems are in place. There are security cameras that monitor the entrances. Staff and residents interviewed confirmed they feel safe at all times.  Call bells are located in all resident areas. Resident and family/whānau interviews confirm call bells were answered in an acceptable timeframe. Monthly inspection is recorded for the call bell system. |
| 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 are heat pumps throughout the facility to provide adequate heating and cooling. Each resident room and living area has adequate ventilation and natural light through external windows and doors. The residents report satisfaction with the heating and ventilation. |
| 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 RN is the designated infection control co-ordinator. The co-ordinator confirms that a surveillance programme is maintained.  Surveillance data is sighted and includes infection details related to clinical files sampled.  Monthly analysis and an annual review of the infection control programme is completed. Reports are provided at monthly general staff meetings. Minutes are sighted.  Interview with the GP and a review of clinical files and medication charts shows antibiotics are 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 complete hand hygiene and use personal protective equipment appropriately.  Outbreak kits are sighted and are accessible and appropriately stocked.  Hand sanitizer is readily available to residents, staff and visitors. Staff are able to identify infection control team personnel. |
| 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 are available and the co-ordinator is able to demonstrate that available external resources are utilised to ensure current best practice. During a recent suspected outbreak, staff followed District Health Board outbreak notification guidelines. Documentation is sighted to confirm this and includes a plan of care for a resident who required isolation. Lab reports sighted and staff confirm the suspected outbreak was not infectious. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Education has been provided to staff around infection control and is also included in the orientation process. Training sessions are documented and attendance records completed. Minutes of general staff meetings sighted include discussions related to infection control practices.  The infection control coordinator has had training around infection control specific to the role and the certificate displayed. |
| 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 confirms a surveillance programme is maintained. Surveillance data is sighted and includes infection details related to files sampled. Monthly analysis is completed and reported at monthly general staff meetings. Benchmarking data against other facilities is sighted.  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 | A restraint policy is sighted and is appropriate for this service. No restraints are used in this facility.  Staff have been provided with education. Staff describe enablers as being voluntary as per the policy and the policy defines both enablers and restraints. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Interview with the RN confirms there is no process to ensure a reconciliation process for medications as they are received into the facility.  Four of ten medication charts sighted had ‘as required’ medications which did not include indications for use. | There is no reconciliation process for receiving medications into the facility.  As required medications do not consistently include indications for use. | Develop a reconciliation process for receiving medications into the facility.  Ensure all ‘as required’ medications include indications for use.  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.