# M & K Atkins 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 Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** M & K Atkins Limited

**Premises audited:** The Waratah Retirement Home

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

**Dates of audit:** Start date: 27 May 2015 End date: 28 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:** 53

# 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

Waratah Retirement Home provides rest home level care for up to 58 residents.

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

Strengths of the organisation include the activities programme and the positive feedback received about the personalised care and services provided. There are four shortfalls identified in ensuring there is sufficient evidence documented related to the collation and analysis of quality data, open disclosure, medicine management and time frames for care planning.

## Consumer rights

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

Staff demonstrated 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).

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

Written consent has been obtained from the residents' or their enduring power of attorney (EPOA) when appropriate.

The organisation provides services that reflect current accepted good practice. Evidence-based practice was observed, promoting and encouraging good practice.

Linkages with family and the community are encouraged and maintained.

The service has a documented complaints management system which was implemented. There were two 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. |  | Some standards applicable to this service partially attained and of low risk. |

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 day to day operation of the facility is undertaken by staff that is appropriately experienced, educated and qualified.

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; however, there is a lack of documented evidence to show the evaluation of corrective actions and this needs to be addressed. The quality management system includes an internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff, residents and family/whānau, as appropriate. Not all of the quality data documents a collation and analysis of findings; this is an area of required improvement that requires addressing.

The service maintains their 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. Initial assessment, care and support are provided by competent staff, with ongoing evaluations completed by a registered nurse. Nursing interventions are consistent with best practice and care plans well utilised. Input from residents, families and allied health professionals is included in the development of care plans and during the evaluation process, however, timeframes for service delivery were not consistently identified due to documents not always being signed and dated.

There is a broad range of activities which are appropriate for the service users. Residents and families interviewed confirmed 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.

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 and an approved evacuation scheme. The service has undertaken refurbishment of the facility but no changes were required to the evacuation plan.

The facilities meet residents’ needs and provide furnishings and equipment that is regularly maintained. All rooms are single occupancy and have ensuite toilets and showers. There are a number of outside areas, lounge areas and a central dining area to meet residents' relaxation, activity and dining needs.

The facility is adequately heated and ventilated. Opening doors and windows create good air flow to keep the facility cool when required. The outdoor areas provide suitable furnishings and shade for residents’ use. Residents and family/whānau were happy with the environment provided.

## 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 provided 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 | 41 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 4 | 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) was displayed throughout the facility. New residents and families were provided with copies of the Code as part of the admission process. Staff 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 | Staff demonstrated the ability to provide information that residents require in order for the residents to be actively involved in their care and decision-making. Staff acknowledged the resident's right to make choices based on information presented to them. All resident files had consent forms signed by the resident or by the enduring power of attorney (EPOA). No residents had made advance directives in the resident files reviewed. Staff demonstrated knowledge on acting on advance directives when these have been made by the resident. The service is implementing a process for advance care planning and capturing residents wishes for end of life care. |
| 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 interviewed 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 are listed in the resident’s information booklet, with the brochure available at the entrance to the facility. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The families reported that there are no restrictions to visiting hours and they are made to feel welcomed at all times. The service maintains links with the community through outings and coach trips each weekday. Some residents report that they are supported to have visits home to their families and maintaining connections with community organisations, such as the RSA. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints management is implemented to meet policy requirements. 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. There is a weekly audit to ensure the contents of the complaint folders throughout the service have the appropriate policies, forms and brochures to assist in making a complaint. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. Residents and family/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time.  There are two outstanding complaints that were received through the Ministry of Health and DHB related to the care provided to one residents. The complaint register records that the service was visited by the DHB in May 2015 as part of their investigation into these complaints. Though these were not resolved at the time of audit, the service has evidenced that they are following their complaints management process that complies with Right 10 of the Code.  The service also maintains a compliments register that has numerous positive feedback about the care and services provided at Waratah Retirement Home. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The family/whanau and residents reported that the Code was explained to them on admission and was part of the admission pack. Nationwide Health and Disability Advocacy service information is part of the admission pack and displayed throughout the facility. |
| 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. Family/whanau reported that their relative is treated in a manner that shows regard to the resident's dignity, privacy and independence. The residents, family/whanau and general practitioner (GP) expressed no concerns with abuse or neglect, with a number of reports and feedback provided on their high satisfaction with the way that the service provides 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 management team reported that there are no barriers to Maori accessing the service. Staff education has been conducted on the Maori philosophy of care that is reflective with the individual needs of residents who identify as Maori. Staff 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 | Evidence:  The residents' files record the resident's individual values and beliefs. Staff demonstrated good knowledge on respecting resident’s culture, values and beliefs. The resident and families report that the staff are very good at providing culturally appropriate care. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff files had job descriptions, employment agreements and staff handbooks that had clear guidelines regarding professional boundaries. The families and residents reported they are happy with the care provided. The families expressed no concerns with breaches in professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, and links with the other health providers. The DHB care guidelines for aged care are utilised. There is regular in-service education and staff access external education that is focused on aged care and best practice. The families and residents were satisfied with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Follow up from complaints received through the HDC and DHB: The families interviewed report they were kept updated during an incident of scabies and were informed of the actions that were implemented to address the issue. Also refer to the infection control standards for the actions that were implemented. The families reported that being kept informed is one of the strengths of the organisation.  The service promotes an environment that optimises communication through the use of interpreter services as required and staff education related to appropriate communication methods has been conducted. An example of processes in place to access appropriate communication resources for residents with special needs was observed. Policies and procedures are in place for accessing interpreter services.  The family/whanau interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident, though this was not always documented on the incident accident form or in the progress notes. Refer to 1.1.9.1 to ensure that there is documented evidence of open disclosure. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Services are planned to meet the needs of the residents at rest home level of care. The rest home residents are mobile and clinically stable. The manager reported that in addition to the direct care services provided, there is an emphasis on the activities programme and prompting an environment that maximises residents’ independence and linkage with the wider community. Residents and family/whānau confirmed that their needs are met by the service.  The strategic business plan documents that the organisation’s quality goals, objectives, and scope of service delivery is reviewed annually. The plan documents the mission statement, philosophy, values and quality objectives. The plan sets goals and objectives for 2015, which include maintaining compliance with these standards and contractual requirements with the DHB, refining the internal audit process, staff training and education and maintaining a safe environment. The Goals and objectives for 2015 also include a project for electronic resident records and the medication management system. There is a monthly management/continuous quality improvement (CQI) meeting that monitors and evaluates progress with meeting goals.  The management team consist of the manager (owner), clinical nurse manager and quality manager. The manager has the overall responsibility for service delivery with the clinical nurse manager having the responsibility for the clinical aspects of service devilry. The clinical manager is a suitably qualified and experienced registered nurse (RN) with a current practicing certificate. All members attend education appropriate to the role they undertake. Job descriptions identify management members’ experience, education, authority, accountability and responsibility for the provision of services. |
| 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 manager and quality manager fill in for each other during temporary absences. During temporary absences of the clinical nurse manager, the clinical management role is shared between the RNs. The manager and RNs reported they are given additional time to undertake the clinical nurse managers role 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. | PA Low | The service has quality and risk management systems to minimise risks to resident’s, staff and visitors. Systems are in place to protect the organisational financial risks and standing in the community. The service has a documented health and safety programme implemented which includes managing hazards, reporting and investigating accidents, planning for emergencies, and health and safety education to ensure staff, visitors and contractors meet the standards. The service had a documented continuous quality plan which identified risks and shows the strategies in place to manage risks.  All quality and risk issues are discussed monthly at staff and management/quality meetings. The key components of service delivery (complaints, incidents and accidents, health and safety, hazards, restraint and infection control) are explicitly linked to the quality management system and outcomes documented identify how each outcome is measured on a monthly basis at the management, health and safety/infection control and quality meetings to review progress against required outcomes. In response to the Ministry of Health and DHB request to review complaints they have received, it is noted in the corrective actions that have been recently implemented included precautionary and preventative measures to minimise the risk of scabies.  All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. Each policy sighted had version control verification in the footer. There is an internal auditing process to review policies and procedures, with input from the management and quality teams. When policies are updated, changed or new policies introduced, these are distributed to staff to read and sign. The document control system ensures that obsolete documents are removed from use.  The service has a comprehensive internal auditing programme that covers all aspects of service delivery. The management and quality teams are in the process of reviewing the internal audits to ensure meaningful outcomes are achieved with the number and type of audits under review. Regular audits are undertaken and corrective action planning put in place to manage any shortfalls found, though the collation, analysis and evaluation of finding is not always documented on all internal audits (refer to 1.2.3.6). Staff confirmed that any follow up actions were discussed during handover and at regular staff meetings.  Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. The service has tertiary certification with an external workplace health and safety programme. |
| 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 follow up from complaints regarding the service not notifying DHB of a scabies infection identified that the service completed a section 31 notification form to the Ministry of Health and an outbreak notification form to the DHB. These were sighted in the services action plan that was implemented after one resident was confirmed with scabies and five other residents had a rash. Also refer to the infection control standards 3.3.5 regarding infection surveillance.  Staff fully understood their obligations in relation to essential notification reporting and knows which regulatory bodies must be notified. Apart from the infection notification there have been no other incidents or accidents that have required essential notification to the appropriate authorities. Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Staff 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 being reviewed at the management/CQI meetings. |
| 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. Annual practicing certificates were signed for all staff and contractors who require them. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme that covers the essential components of health and safety and service delivery, with specific competencies for their roles.  Staff undertake training and education related to their appointed roles. Staff education includes guest speakers, off site seminars and training days to ensure all aspects of service provision are met. Three RNs who have completed the required interRAI training and one more is scheduled for training in 2015.  Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents’ needs are met by the service. No negative comments were voiced on the days of audit and the service has a register of numerous numbers of compliments about the service, staff and care provided. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix is maintained to meet residents’ needs and to comply with the DHB’s contractual requirements and safe staffing guidelines. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. There is a RN on duty morning and afternoon shifts seven days a week and a RN on call other times. Residents interviewed stated all their needs have been met in a timely manner.  In addition to the direct care staff, there is a manager, clinical nurse manager and quality manager who work weekdays. The manager reported that additional staff would be rostered to meet residents’ needs if the need arose. A review of rosters shows that staff are replaced when on annual leave or sick leave. There are adequate numbers of non-clinical staff which include activities, housekeeping, kitchen, coach driver and maintenance staff. Staff confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs. |
| 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 are stored onsite. When required, records are appropriately destroyed.  There are at least daily progress note entries. These records were legible and the name and designation of the staff member documented also refer to 1.3.3.3 regarding the signing and dating of clinical records. All records pertaining to individual residents are 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 | Entries 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 confirmed the necessary needs assessments have been completed and residents placed in an appropriate level of care. Signed and dated admission agreements were sighted and staff interviewed verified the processes which ensured 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 confirmed the correct processes are followed around exit and discharge. Referral information provided to other service providers was sighted on clinical files and copies of correspondence retained. |
| 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. Staff were 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 confirmed that only staff who have been assessed as competent are responsible for medication management. Medication trolleys and cupboards were 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. All charts include photo identification and any allergies identified. Three monthly GP reviews were evident. Individually prescribed medications are used and a blister pack system utilised.  Three medication files sampled included residents who self-administer medication. Residents have been assessed as competent to self-administer medications and the relevant form confirming this was signed by both the resident and the RN. A medication fridge was observed and daily monitoring of temperature 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 confirmed that there is dietitian input into the menu and the relevant report confirming this was sighted. A four weekly menu is followed and the meals provided on the day were in line with the menu sighted. Residents interviewed were 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 were sighted and any allergies identified.  Kitchen staff have required food safety qualifications.  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 are on all containers, and food in the chiller was 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 was no evidence of potential residents being declined entry. Clinical staff interviewed were able to give reasons for declining entry and the general practitioner (GP) confirmed 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 and include resident centred goals.  Residents and families interviewed confirm 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 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 included resident centred goals.  Clinical staff interviewed confirmed access to resident files and completion of daily progress notes demonstrate prescribed care was completed.  There was evidence of allied health support within the care plan process, for example, specialist services.  Residents observed have the necessary prescribed equipment to minimise risk and promote independence. The GP describes 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 are developed as required, for example, for one resident who recently developed an infection.  Documentation completed daily by care staff confirms care was being completed as prescribed.  Observation of clinical staff handover demonstrated 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 was 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. With regard to a recent complaint, the service provides daily outings (Monday-Friday) on a coach/mini bus which is owned by the service. Outings are for one to two hours and involve taking small groups of residents sightseeing. There is a designated coach driver who is suitably trained, which enables the activities co-ordinator to focus on activities at the facility.  Residents interviewed confirmed a very high degree of satisfaction with the outings and activities in general, and confirm participation is voluntary. There are walking groups which residents are supported to participate in daily. There is ample space outside the facility for residents to safely mobilise, with access to gardens. Support is provided for individuals to attend activities specific to their needs with one to one support as necessary. Residents were observed participating in the days planned activity; they were well supported and appeared to be enjoying the activity. Participation records are maintained. 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 | A policy describes an evaluation process. Files sampled included evaluations which were documented according to policy; they are conducted regularly and described the degree of achievement and progress towards meeting desired outcomes. The RN described the process, and evaluations sighted showed 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 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 and family members confirmed that residents are provided with access to other service providers as required.  Files demonstrated 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 stated they have been kept fully informed during the referral process, and documentation in progress notes demonstrated communication with family and other health professionals. |
| 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 are appropriate processes in place for the management of general waste, clinical waste, recycling and hazardous substances. Chemicals are stored securely. 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 as required and have undergone training in the management of waste and hazardous substances. |
| 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 July 2015.  Maintenance is undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurs annually and was completed in February 2015 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 or when required.  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. Regular environmental audits sighted identified that the service actively works to maintain a safe environment for staff and residents.  The service identified planned annual maintenance in their business plan and is undertaking a systematic upgrade of all bedrooms. They have completed seven bedrooms to date. A new dining area and entrance foyer have been completed. There are easily accessed, level surface, shaded outdoor areas for residents.  Interviews with 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. Each room has ensuite facilities with shower, toilet and basins. 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. They are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and stated that 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. Each wing has a number of lounge areas. These areas are appropriately furnished to meet residents’ needs. Activities are undertaken in lounge and dining areas at various times throughout the day and do not impact on each other. 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 and laundry processes. There are secure storage area for cleaning equipment and chemicals. The housekeeping staff conducted the cleaning and residents personal laundry. There is a cleaning schedule that is maintained daily. The facility looks and smells clean. The service has recently implemented a steam cleaning process for resident’s rooms, bedding and clothing in response to a previous infection outbreak. The residents’ personal laundry is done onsite, with a contracted company doing the linen offsite. During interview, residents and family/whānau confirmed they are happy with the laundry services provided. Staff interviewed confirmed they always have enough laundry 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 (approval date May 2008). The service is fitted with smoke alarms and a sprinkler system. The service has a generator for energy and utility sources are available in the event of the main supplies failing. Emergency education and training for staff includes six monthly trial evacuations.  Appropriate security systems are in place. This includes locking doors after hours and a wander alert system. Staff and residents interviewed confirmed they feel safe at all times.  Call bells are located in all resident areas. The call bell system sends a pager alert to the care staff when the call bell is activated. Resident and family/whānau interviews confirm call bells were answered within acceptable timeframe. |
| 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 | Resident areas have at least one opening window to provide natural light and ventilation. Heating is supplied by wall mounted electric storage heaters. The heaters are on timer system. Resident’s rooms were warm on the day of audit. Resident and family/whānau interviews confirmed the facility is kept at a suitable temperature throughout the year. |
| 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 confirmed that a surveillance programme is maintained.  Surveillance data was sighted and included infection details related to clinical files sampled.  Monthly analysis and an annual review of the infection control programme were completed. Reports are provided for clinical team meetings and health and safety team meetings. Minutes were sighted. Two weekly education sessions are used as a forum to share information related to infection control as necessary, for example, for recent scabies outbreak.  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 were sighted and are accessible and appropriately stocked.  Hand sanitizer is readily available to residents, staff and visitors. Staff were able to identify infection control personnel.  With regard to recent complaints, interview with a GP is held and confirmed residents have been seen in a timely manner and prescribed care provided appropriately. Care plans, progress notes and an action plan for scabies confirmed care provided. Staff interviewed and documentation described communication with family members, including advice of referral to specialist services. The GP acknowledged issues around difficulty making diagnosis of scabies and as a result has now purchased diagnostic equipment.  Four residents were suspected of having scabies and were managed according to policy, with procedures followed. Of the four residents, one was confirmed as having scabies. Treatment has been provided, and is now resolved.  The facility has also purchased specialised steam cleaning equipment to ensure eradication of mites. |
| 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 was able to demonstrate that available external resources are utilised to ensure current best practice. Documentation was sighted that confirmed this and included a plan of care for a resident who required isolation. |
| 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 were documented and attendance records completed. |
| 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. Surveillance data was reported at clinical staff meetings, and health and safety meetings on a monthly basis. This information was used to assist in developing procedures and planning education. Minutes of meetings and education records were sighted. An external consultancy firm has provided tools to enable monthly analysis of infections.  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 was sighted and is appropriate for this service. No restraints are used in this facility.  Staff have been provided with education. Staff described 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 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Not all incident and accident forms included evidence that the family had been notified. Some progress notes did record that family have been notified. The families interviewed report they feel that they’re kept fully informed. There is an area for improvement to ensure the evidence of notifying the family is documented on the incident/accident form. | Not all incident/accident forms record that the family had been notified. | Ensure incident and accident forms include evidence of open disclosure.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality data from falls, wounds and infection surveillance is collated, analysed and evaluated. Not all the internal audits reviewed for 2015 document the collation and analysis of findings on the internal audit form. The service is responsive in implementing any actions to address shortfalls, though this is not always captured in the documentation. There is an area for improvement to ensure that the internal audits also capture the analysis of findings. | Not all internal audits conducted documented the collation, analysis and evaluation of the findings. | Ensure all quality data is collated, analysed and evaluated.  180 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 | Six of 16 medication charts had medications prescribed for use as required and included indications for use. | 10 of 16 medication charts included prescribed medications for use as required; however, they did not include indications for use. | Ensure all medications prescribed for use as required, include indications for use.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Five of eight clinical files included an initial assessment completed by a registered nurse within the required timeframe.  One of eight clinical files had a long term plan of care developed within required timeframe. | Three of eight clinical files included an assessment completed by a registered nurse; however, they were not signed and dated.  Seven of eight clinical files had a long term plan of care developed; however, they were not signed and dated. | Ensure documentation is signed and dated on completion  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.