# Nicolson Rest Home 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 and Disability Auditing New Zealand 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:** Nicolson Rest Home Limited

**Premises audited:** Nicolson Rest Home Limited

**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:** 43

# 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

Irwell Rest Home is privately owned and operated and cares for up to 60 residents requiring rest home level care. On the day of the audit there were 43 residents.
The audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

The two owners manage the facility and are well experienced and qualified for the role. They are supported by three registered nurses. Resident and relative feedback was positive about the service provided. This audit has identified one area for improvement around transcribing of medications.

## Consumer rights

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

The staff at Irwell ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints and concerns have been managed and a complaints register is maintained.

## 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. |

Irwell has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to quality improvement and staff meetings. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and analysed for trends. There is an orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## 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. |

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| 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. |

Irwell Rest Home has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner’s room. The service has implemented policies and procedures for civil defence and other emergencies and regular fire drills are conducted. External garden areas are available with suitable pathways and seating. Smoking is only permitted in a designated area.

## 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 is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were no residents requiring restraints or using enablers. The service reviews restraint as part of the quality improvement meetings.

## 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 control management systems are in place to minimise the risk of infection to residents, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation.

## 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Discussions with staff (six caregivers, three registered nurses, the two owner/managers and the activities coordinator) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Seven residents and two relatives were interviewed and confirmed the services being provided are in line with the Code. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent and advanced directives were recorded as evidenced in the seven resident files reviewed. Staff interviewed reported that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements sampled were signed. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Contact numbers for advocacy services are included in the policy, in the resident information pack and in advocacy pamphlets that are available. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident’s life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Systems and processes have been in place to ensure that any complaint received is managed and resolved appropriately. Three complaints have been received in 2015 to date. These were reviewed and show appropriate acknowledgement, investigation and resolution within required timeframes and all are discussed at staff meetings. Residents and family members advised that they are aware of the complaints procedure and how to access forms.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they were well-informed about the Code. Resident meetings and a family survey provide the opportunity to raise concerns. Advocacy information and information about the Code is included in the information pack and are available at the service.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. Interdenominational church services are held fortnightly and there is weekly Catholic communion. Resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and recent training on abuse and neglect has been provided.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | The service has a Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently two residents at Irwell who identify as Maori. The service has some Maori staff and documented links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes signing the code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. The registered nurses have completed training around professional boundaries. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The administrator is responsible for coordinating the internal audit programme with support from the registered nurses. Staff meetings and residents meetings are conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of the principles of aged care and state that they feel supported by the owner/managers. Care staff complete competencies and questionnaires relevant to their practice.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Incident reports support this. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur approximately two monthly and the owner/managers have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Irwell Rest Home is privately owned and operated. The service provides care for up to 60 residents at rest home level care. On the day of the audit, there were 43 residents.The service has been managed by the experienced owner/managers who have been in the role for 17 years. The current business plan including service goals has been implemented and all goals for 2014 were documented as achieved. The owner/managers receives support from two full times and a part time registered nurse. The owner/managers have completed eight hours of management related training in the past year by attending DHB meetings. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | The clinical lead/ registered nurse provides cover during a temporary absence of the owner/managers.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk policies describe Irwell’s quality improvement processes. Progress with the quality and risk management programme has been monitored through the bi monthly quality improvement meetings. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and caregivers confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. This data is analysed for trends and graphed with graphs displayed in staff areas. The internal audit schedule for 2014 has been completed and the 2015 has been commenced. Areas of non-compliance identified at audits have a corrective action plan. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has policies/procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed two yearly. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death. Falls prevention strategies are implemented for individual residents.  |
| 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 | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of 13 resident related incident reports for April 2015 was reviewed. All of the 13 reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | The recruitment and staff selection process requires that relevant checks have been completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 15 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This was documented for staff employed since the previous audit. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. Annual appraisals are conducted for staff. A completed in-service calendar for 2014 exceeded eight hours annually and has commenced for 2015 and covers all required topics.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Irwell has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The registered nurse/care lead works 40 hours per week, another registered nurse works 16 hours per week and the recently employed quality improvement officer is a registered nurse who works 40 hours per week, at least one day of which is clinically focussed. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ office. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder. |
| 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 | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment is completed on admission. The service has specific information available for residents/EPOA at entry and it includes associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The transfer/discharge/exit procedure includes a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation are forwarded with the resident. |
| 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 | The service uses individualised medication blister packs which are checked in on delivery. A medication competent caregiver was observed administering medications correctly. Medications and associated documentation are stored safely and securely and all medication checks are completed and meet requirements. Medications are reviewed three monthly with medical reviews by the attending GP, or as condition changes. Resident photos and documented allergies or nil known were on all 14 medication charts reviewed. An annual medication administration competency is completed for all staff administrating medications and medication training had been conducted. There is a self-medicating resident’s policy and procedures in place; however, there are currently no residents who self-administered medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All medication charts reviewed recorded indication for use of as required medication by the GP. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. All medication charts reviewed had been transcribed by the registered nurse. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Irwell Rest Home are prepared and cooked on site. There is a six weekly rotating menu, which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room and served directly to the residents. There is also an option of residents’ using a small dining room and meals are delivered to them. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurse or caregivers. Weights are monitored monthly or more frequently if required and as directed by a dietitian or GP. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| 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 | The reason for declining service entry to residents is recorded on the declined entry form. When this has occurred, the service stated it had communicated to the resident/EPOA/family and the appropriate referrer.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted with a care needs level assessment completed by the needs assessment and service co-ordination team prior to admission. Files reviewed included a needs assessment for rest home level care. Personal needs information is gathered during admission, which forms the basis of resident goals and objectives. Assessments reviewed were reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues. The registered nurse has completed InterRAI training and the assessment tool was evident in resident files.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident care plans reviewed included interventions to support current resident needs. The long-term care plan records the resident’s problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that includes documenting interventions to support short-term cares. The acute health needs care plan was noted to be in use when a resident’s condition had changed. Residents’ files reviewed identified that family were involved in the care plan development and on-going care needs of the resident.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Irwell Rest Home were integrating InterRAI assessments and care planning, as evidenced in six of seven resident files reviewed. Care plans reviewed were current and interventions reflected the assessments conducted and the identified requirements of the residents. Interviews with staff and relatives confirmed involvement of families in the care planning process. Monitoring charts were used as directed by RNs. Dressing supplies are available and a treatment room was stocked for use. Continence products are available and resident files included a urinary continence assessment and bowel management. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for ten residents. A wound care specialist had assessed two chronic wounds and put in place nursing interventions which were being followed through by staff. |
| Standard 1.3.7: Planned ActivitiesWhere 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 coordinator provides an activities programme over five days each week. The programme is planned monthly and residents receive a personal copy of planned weekly activities. Activities planned for the day are displayed on notice boards around the facility. A diversional therapy plan is developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for outings. Residents were observed participating in activities on the days of audit. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme, the enthusiasm of activity staff and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Short-term care plans were in use. Care plans reviewed were evaluated within the required time frames.  |
| 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 | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/EPOA are involved as appropriate when referral to another service occurs. |
| 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 | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts are available and the hazard register identifies hazardous substances. Gloves, aprons and goggles are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires on 23 November 2015. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | The majority of resident rooms have ensuites. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs. |
| 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 | The resident rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and separate dining room. The main dining room is spacious, and located directly off the kitchen/servery area. There is also a smaller dining room available for residents’ who choose to use them. All areas are easily accessible for the residents. There is a large lounge/activity room, plus smaller lounges. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assist them when required. Activities take place in any of the lounges. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. There are secure cleaners cupboard with cleaners trolleys. Manufacturer’s data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. Laundry and cleaning are monitored through the internal auditing schedule.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures plan. The fire evacuation scheme was approved in 1997. All senior staff have a first aid certificate and there is a senior staff member on duty at all times. Fire safety training has been provided. A call bell light over each door and a panel alerts staff to the area in which residents require assistance. Fire drills have been conducted six monthly. Civil defence and first aid resources are available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed.  |
| 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 | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment is warm and comfortable. |
| Standard 3.1: Infection control managementThere 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 | Irwell has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The care lead/registered nurse is the designated infection control coordinator. Infection control matters are discussed at quality improvement and staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Irwell. Infection control team is the quality improvement team and representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.  |
| Standard 3.3: Policies and proceduresDocumented 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 | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. Education is facilitated by the DHB infection control nurse. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there have been no recent outbreaks). Information is provided to residents and visitors that are appropriate to their needs and this is documented in medical records. Education around infection prevention and control has been provided in 2014 and hand washing and personal protective equipment sessions in 2015 run by the infection control coordinator.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an important part of the infection control programme and is described in policy. The care lead/registered nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet and then entered on the annual summary. The data is evaluated monthly for trends with graphs produced and displayed and discussion at staff and quality improvement meetings. Infection surveillance outcomes are used to improve infection control practices.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. There were no residents requiring restraint or enablers at the time of the audit. The use of enablers would be voluntary and requested by the resident as reported by the registered nurses.  |

# 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Three monthly GP reviews were documented. Medication charts had documented evidence GP signing for prescribed medications, allergies identified and a resident photograph. As required medication included the indication for use. Currently the registered nurse writes the medication charts at the GPs request. The GP then individually reviews each entry on the medication chart, signs and dates each one, making changes as required.  | The registered nurse has been transcribing the medication charts. It is from the GPs direction the medication charts are being transcribed by the Registered Nurse | Cease the practice of transcribing.30 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.

|  |
| --- |
| No data to display |

End of the report.