# Kirsty Schofield

## 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 The DAA Group 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:** Kirsty Schofield

**Premises audited:** Cornwall Resthome

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

**Dates of audit:** Start date: 24 June 2015 End date: 25 June 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:** 25

# 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

Cornwall Resthome provides rest home level care for up to 27 residents. There were 25 residents on the first day of this audit.

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

Residents and family members interviewed were very positive about the care provided.

There are nine areas identified that require improvement relating to quality improvement data, aspects of human resources management, staff education and competency, resident documentation, including assessment evaluation and timeframes, and monitoring of restraint use.

## Consumer rights

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, was accessible. This information was brought to the attention of residents (where able), and their families, on admission to the facility. Residents and family members interviewed confirmed their rights were met, staff were respectful of their needs and communication was appropriate.

Residents and family interviewed confirmed consent forms are provided. They also confirmed they are given whatever information they require prior to giving informed consent. Residents and family also advised that time is provided if any discussions and explanation are required.

Staff receive regular and ongoing training on resident rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents. All aspects of service delivery are consistent with upholding and respecting residents’ rights.

During the audit visit, residents were observed being treated in a professional and respectful manner. Residents and their families reported their satisfaction with the services provided, and of the open communication with staff. Policies are in place to ensure residents are free from discrimination or abuse and neglect, with these policies well understood by staff.

The facility manager is responsible for the management of complaints and a complaints register is maintained

## Organisational management

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| --- | --- | --- |
| 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 medium or high risk and/or unattained and of low risk. |

Cornwall Resthome is privately owned and the owners are responsible for the service provided at this facility. Planning documents reviewed included a business plan, quality and risk management plan, a mission statement, values, and philosophy.

The two owners work in the business. One is appointed as the facility manager and the other overseas the general environment including maintenance. The manager is a non-clinical manager and is supported by two registered nurses who are responsible for oversight of clinical care. Registered nurse cover is provided five days a week.

There was evidence that quality improvement data has been collected, collated and reported, however the data is not being analysed to identify trends. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed to address areas identified as requiring improvement, however, timeframes for completion, who is responsible for the corrective action and review is not documented. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management. Staff records reviewed provided evidence not all human resources processes have been followed, including reference checking and police vetting. Staff education records confirmed in-service education is provided. Not all staff has received training related to managing challenging behaviour and clinical staff have not completed restraint competency assessments. The validation of current annual practising certificates for health professionals who require them to practice has occurred.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is one caregiver and one staff member on call. The facility manager and a registered nurse are available after hours if required. Care staff, residents and family reported there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The legibility of the name and designation of staff making entries into residents’ clinical records is an area requiring improvement.

## Continuum of service delivery

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| --- | --- | --- |
| 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 medium or high risk and/or unattained and of low risk. |

A range of strategies are in place to guide continuity of care, including resident progress notes being updated every shift, written handover sheets and verbal handovers at the start of each shift.

Residents have individualised care plans, which are based on an integrated range of clinical information and resident/family input. Developing and evaluating care plans within required timeframes, the frequency of clinical assessments/reassessments and the evaluation of resident progress toward planned outcomes are areas for improvement.

Food services are a strength of the service, with residents speaking highly of the meals provided to them. The kitchen was well organised and maintained in a clean and hygienic manner. The individual food preferences and dietary needs of residents are acknowledged and accommodated. There are two separate dining areas for residents.

The management of medications is safe and appropriate. Medications are administered by registered nurses and senior caregivers, all of whom have been assessed as competent in relation to medicines management. Medications are prescribed in accordance with legislative and safe practice requirements and stored appropriately.

An experienced recreational officer manages the activity programme. A range of activities are available to residents, who are also encouraged to maintain their links with the community. Regular outings are undertaken using the facility’s mobility van.

## Safe and appropriate environment

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

All residents’ bedrooms provide single accommodation and have wash hand basins. Five rooms also have toilet facilities. Residents' rooms were observed to be of varying sizes and adequate personal space is provided in bedrooms. Lounges and dining rooms are available for residents to sit. External areas are available for sitting and shading is provided.

An appropriate call bell system is available and security systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring systems, are in place to evaluate the effectiveness of these services.

The preventative and reactive maintenance programme includes equipment and electrical checks.

## Restraint minimisation and safe practice

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

Policies and procedures comply with the Standard for restraint minimisation and safe practice. One of the registered nurses is the restraint coordinator. A restraint register is maintained. Risk assessment, documentation, maintaining care, and reviews were in place. The resident using restraint had no restraint-related injuries. Staff have received education relating to restraint; however, clinical staff have not completed competency assessments. Not all staff have received on-going education relating to challenging behaviour.

## Infection prevention and control

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| 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. |

Policies are in place to guide infection prevention and control across the service. The infection control coordinator has extensive experience in the role and has received relevant training. An appropriate range of personal protective equipment is available to staff. Monthly reports are developed arising from infection surveillance, with results reported to the quality committee and shared with staff.

## 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 | 43 | 0 | 1 | 6 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 2 | 7 | 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 | All new staff receive education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code) as part of their orientation programme. Annual education on the Code is also provided to all staff. This was sighted in staff education records and confirmed in staff interviews. Staff also demonstrated a good understanding of the requirements of the Code, outlining how these were then incorporated into their everyday practice. |
| 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 | The informed consent policy guides service providers in relation to informed consent. Evidence was sighted in resident files of formal, documented consent related to general consent (personal and nursing care, primary medical care) and permission to collect and store information. Consent is also obtained on an as-required basis, such as for the recent ‘flu’ vaccinations.  All resident records sighted contained a completed resuscitation form which included input from the resident/Enduring Power of Attorney (EPOA) and the doctor. An advance directive completed some years ago by one resident was included in their clinical file.  Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with the resident and in particular spoke highly of being kept informed about what was happening with the resident, and consulted when treatment changes were being considered.  The admission agreement completed by each new resident and/or their family member identified inclusions and exclusions in service. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff training records. Staff demonstrated their understanding of the Advocacy Service, with contact details for the service readily available.  Residents are provided with information on the Advocacy Service as part of the admission process. Residents and family members confirmed their awareness of the Advocacy Service and how to access this, although all stated they would feel very comfortable about approaching the facility manager should they have any concerns. |
| 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 | Residents are encouraged to maintain their community interests and networks, and to visit with their families. The service’s activities programme includes regular outing in the facility’s mobility van and participation in community events such as concerts and quiz events. Community groups and entertainers also visit the facility regularly.  The service welcomes visitors, and has unrestricted visiting hours. Family members advised they felt very welcome when they come to visit. Residents are well-supported by staff to access health care services outside of the facility, such as visits to the dentist or the audiologist. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The facility manager is responsible for complaints and there were appropriate systems in place to manage the complaints processes. A complaints register was maintained that included one verbal complaint since the previous audit and this was managed appropriately.  The facility manager advised there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes.  Observations provided evidence that the complaint process was readily accessible and/or displayed. Review of quality meeting minutes provided evidence of reporting of complaints to staff. Care staff interviewed confirmed this information is reported to them via the quality and staff meetings. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | During the admission process, new residents and their family/whanau are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service). The facility manager advised this information is discussed with them during the admission process and any questions they may have are answered. Staff are also available to discuss the Code and/or the Advocacy Service with the individual resident and/or their family at any other time if they require additional information or clarification. Posters of the Code are also displayed at the facility.  Residents and family members were familiar with the Code and the Advocacy Service. Although none of those interviewed had any concerns about any aspect of the services being provided, all stated they would feel very comfortable raising these with any of the staff, but especially with the facility manager who was considered to be very approachable and responsive to any issues raised. |
| 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 | During the audit visit, staff were observed to interact with residents in a warm, friendly and supportive manner. Residents were addressed by their preferred names. Each resident has a private room, which they are encouraged and supported to personalise. Staff were observed knocking on closed doors before entering, and maintaining the privacy and dignity of residents during personal cares. During interview residents and family members confirmed they were treated respectfully and that the individual needs and preferences of residents were acknowledged and accommodated. The resident satisfaction survey completed in late 2014 indicated high resident satisfaction (between 95-100% satisfied/very satisfied) about their rights being respected, privacy maintained and their preferred name being used.  All resident records reviewed included documentation related to individual cultural, religious and social needs, values and beliefs, which had then been incorporated into their individual nursing care plan. The plans also included information on the resident’s abilities, and strategies to maintain/maximise their independence. Evidence was sighted that these plans had been developed in conjunction with the resident and/or their family.  Privacy of resident information was maintained. Resident’s personal information in electronic files was password protected; clinical files in current use were kept in a filing cabinet which was locked when staff were not present, or in a locked office. Staff were mindful of maintaining privacy of information during staff handovers. Archived materials were stored securely.  The service’s policy related to abuse and neglect was well understood by those staff interviewed, who were able to give examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff education related to abuse and neglect has been undertaken in the past twelve months. The Facility Manager reported that staff were not allowed to accept any gifts from residents. Staff employment contracts also contain information related to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met. |
| 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 | The service has a well-developed policy and processes related to meeting the needs of residents who identify as Maori. The facility manager also detailed the networks that have been established locally if additional support is required to support any residents who identify as Maori. A staff member who identifies as Maori is also available to support staff and takes the lead in ensuring that the rooms of deceased residents are blessed prior to the next resident being admitted. The service has a specific cultural assessment tool for residents who identify as Maori, designed to identify specific cultural needs, and this has been initiated for the one resident who identified as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The individual preferences, values and beliefs of residents were included in all care plans reviewed. These plans included detailed interventions to ensure resident’s individual requirements were accommodated.  Residents and family members advised they had been consulted about the resident’s individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation. The nurse practitioner also expressed confidence that residents were not being discriminated against in any manner.  The facility manager advised that the orientation for new staff includes education related to all forms of discrimination and exploitation. Information on this topic is also included in each staff member’s employment contract. Staff are not permitted to accept any gifts from residents, and the facility manager expressed confidence that she would be quickly informed by other staff if there were any concerns about a staff member or any of the resident’s visitors.  The staff induction programme includes information related to discrimination and there is regular training for all staff on the topic. When interviewed, staff were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the Wairarapa DHB and Hospice Wairarapa. Clinical policies, which are current and reflect best practice, are available to guide staff in care delivery. Registered nurses are also supported to attend external education sessions, such as palliative care. The nurse practitioner, who visits the facility at least weekly, expressed confidence in the standard of care provided to residents and that they would have no hesitation in recommending the service to prospective residents/families. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A review of accident/incident forms revealed timely and open communication with residents/family members. Communication with family members was recorded on the family communication sheet in the resident’s clinical file, and also in the progress notes. Family members expressed their satisfaction with how well they were kept informed about any change to the resident’s status and their involvement in resident care planning. Resident meetings are held on an irregular basis, and it is recommended that these meetings are held more frequently, with a more structured format.  The facility manager advised that interpreter services were able to be accessed from the Wairarapa DHB if required. This information is also provided to residents/families as part of the information booklet provided as part of the admission process. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | This facility is privately owned and the owners are responsible for the service provided at Cornwall Resthome. A business plan and a quality and risk management plan were reviewed and included goals and objectives. A mission statement, values, vision and objectives were also reviewed. There was evidence of monitoring and review of the goals in the business plan.  The facility is managed by the owners, one is the facility manager and the other is responsible for maintaining the facility. The owners have owned and managed Cornwall Resthome since 1993. The facility manager (FM) is responsible for the day-to-day management of the facility. The two registered nurses (RNs) are responsible for oversight of clinical care. The annual practising certificates for the RNs were reviewed and are current. There was evidence in the FM’s and RN’s files of ongoing education.  The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  The service provider has funding contracts with the District Health Board (DHB) to provide aged related residential care, community residential services with aged care facilities for people with chronic health conditions, and short term health 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 | There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager (FM) be absent. The facility manager reported the administrator fills in for the FM if they are absent and the RNs fill in for each other. The RNs and administrator confirmed their responsibility and authority for these roles.  Services provided meet the specific needs of the resident group within the facility. |
| 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 Moderate | A quality and risk management plan and business plan were reviewed and these are used to guide the quality programme and include goals and objectives.  The administrator is responsible for oversight of the internal audits. Completed internal audits for 2014 and 2015 were reviewed. Family, resident and staff satisfaction surveys are completed as part of the audit programme and collated results for all three surveys were reviewed.  Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual was available that included relevant policies and procedures.  Monthly quality meetings are held. Staff meetings are held two monthly and residents meetings three monthly. Meeting minutes reviewed provided evidence of reporting / feedback on completion of internal audits and various clinical indicators were graphed. Meeting minutes for 2014 and 2015 were reviewed.  Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated and reported. There was evidence that numbers of collated data is being reported to staff via quality and staff meetings, however data is not being analysed to identify trends.  Quality improvement data reviewed, including internal audits and meeting minutes provided evidence that corrective action plans are being developed, however, implementation, monitoring and signing off as being completed was not evident.  Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery. |
| 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 | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by either the FM and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident forms. One of the two registered nurses undertakes assessments of residents following an accident if they are on duty. One of the RNs is available after hours and are contacted if required. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.  There was documented evidence of communication with family and the GP on the accident/incident form and in residents’ progress notes following and adverse event and if there is any change in the resident’s condition. Residents and family confirmed this during interviews. There is an open disclosure policy.  Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).  The FM reported they have not needed to report any essential notifications to external agencies. |
| 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. | PA Moderate | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements and completed orientations. Not all files had evidence of reference checking. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.  The FM is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session were reviewed and provided evidence ongoing education was provided, apart from education provided to all staff. Competency assessment questionnaires were available for medicine management. Competency assessments relating to restraint for clinical staff were not available.  All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.  An appraisal schedule is in place and current staff appraisals were sighted on staff files reviewed.  An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The facility manager advised that staff were orientated for at least two shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.  Care staff interviewed confirmed they have completed an orientation, including competency assessments (as appropriate) apart from restraint. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse (RN) cover is provided five days a week between 8am and 4pm. On call after hours registered nurse support and advice is provided by the one of the registered nurses. The minimum number of staff on duty is during the night and consists of one caregiver.  Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All care staff have a current first aid certificate. Residents and family interviewed reported staff provide them with adequate care. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | Resident related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files were password protected and can only be accessed by designated staff. Some hard copy information is kept in a centrally located filing cabinet and staff reported this was kept locked when no staff were present. Archived material was also kept securely but was easily retrievable.  All components of the residents’ records reviewed included the resident’s unique identifier. The clinical records reviewed were well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.  Detailed resident progress notes were completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes do not clearly identify the name of the person making the entry. |
| 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 | Prospective residents are provided with clear information about the service, including the admission criteria and the processes that must be completed prior to admission. The facility manager advised that residents can only be admitted when their requirement for rest home level care has been has been assessed and confirmed by the Needs Assessment and Service Coordination Service (Focus). The facility also works closely with the Wairarapa District Health Board.  Family members indicated on interview they had found the admission process supportive, that appropriate information had been made available to them, and any questions they had were responded to fully. The service has a comprehensive information booklet which is given to residents/families as part of the admission process. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service uses the Wairarapa District Health Board’s ‘yellow envelope’ system to facilitate the safe transfer of resident information to and from acute care services. The service has also developed its own emergency referral form, which includes a photo of the resident, their past and current medical history, allergies and sensitivities, and EPOA contact details. These forms were sighted in all residents’ files reviewed. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All aspects of medication management comply with legislative requirements and safe practice guidelines. The service has detailed policies and procedures to guide medication management.  Medications are administered by both registered nurses and caregivers. Records were sighted that all these staff have a current medication competency assessment.  Medications are supplied to the facility using the blister pack system. The registered nurse advised that these packs were checked by one of the registered nurses against the medication chart. Records of these reconciliations were sighted. Surplus and expired medication is returned to the pharmacy. The date of first use of eye drops was recorded on those products currently in use. A stocktake of all controlled medication is undertaken weekly. Records of the weekly check of the medication fridge temperature were sighted, with the temperature being maintained within the required range.  Medication charts reviewed confirmed that medications were charted in an appropriate manner, with discontinued medications initialled and dated. Standing orders are not used. All medication charts included a current photograph of the resident. One resident partly self-medicates, with documented evidence sighted of three-monthly assessments of their ability to do so.  An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. Medication was checked against the medication chart prior to verbally confirming the resident’s identity before administering the medication, observing the medications were taken, and administration being documented. |
| 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 | Food services are a strength of the service. Residents and family members spoke highly of their enjoyment of meals and how they were offered alternatives if they did not like something on the menu. Satisfaction with food services was also evident in the 2014 resident satisfaction survey.  Food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Cleaning schedules were sighted. Records were sighted that fridge and freezer temperatures were monitored daily and remained within recommended ranges. On inspection, the kitchen was well maintained, clean and tidy. The kitchen catered for a range of nutritional requirements, including diabetic and soft diets. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs are recorded. A four weekly menu is in place, and is to be reviewed again by a registered dietician at the beginning of July.  Experienced and appropriately qualified staff are responsible for food services within the facility. Both cooks have completed NZQA Unit Standard 167 food safety. The cook advised that staff advise when resident’s nutritional needs change and prescribed nutritional supplements are administered. Specialised crockery, such as lip plate and feeding cups, are available. There are two dining rooms available for residents. One of these dining rooms is immediately adjacent to the open-plan kitchen and during the audit visit this was noted to be a favourite location for the male residents in particular to socialise. |
| 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 service frequently has a waiting list. The facility manager advised that if there is no vacancy, or a prospective resident did not meet the entry criteria, they and their family would be referred back to Focus and supported to find alternative placement. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | Residents are assessed by a registered nurse within 24 hours of admission. A short term care plan is developed utilising a range of information provided by the resident/family, hospital discharge summaries, the NASC assessment, and clinical assessments undertaken by the service, such as falls risk and pressure area risk. In one care plan, the routine clinical assessments had not been completed in a timely manner.  One staff member has completed the interRAI training, with 12 residents entered onto the system. There was evidence that the information generated by the interRAI assessment, especially the identified triggers, being well-utilised as part of the care planning process. The nursing care plan format has recently been adapted to improve compatibility with the interRAI assessment tool.  The ongoing assessment of routine clinical indicators was erratic. The reassessment of condition-specific indicators, such as pain levels, was also erratic.  Residents and families reported their satisfaction with their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Individualised resident care plans were sighted. These plans included individual needs/preferences, residents’ functional abilities, and details of interventions required to support their identified needs. There was evidence of a range of assessment information, such as the Support Needs Assessment, and the interRAI assessments, being incorporated into the care plans. Residents’ clinical records are integrated, with the exception of wound care plans, which are kept in a separate folder. Residents and families reported they felt included in the development of the resident’s care plan and the evaluation of these plans. |
| 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 detailed entries sighted in resident progress notes confirmed that service delivery was consistent with the plans for care. Registered nurses are on site five days a week to provide support and guidance for care delivery staff and are available on call as required. The nurse practitioner, who visits the facility very regularly, expressed satisfaction with the care provided to residents, and noted that they would “never hesitate to recommend this rest home.” |
| 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 recreation officer has 11 years’ experience coordinating the residents’ activities programme and is employed for 20 hours a week. Residents’ previous and current interests are assessed on admission by the registered nurse/facility manager, and individual activity plans completed within three weeks. These plans are evaluated as part of the care plan evaluation process – refer to criterion 1.3.8.2.  The monthly activities programme reflects the assessed resident’s preferences. The facility has its own mobility van and regular outings feature in the monthly activities plan. Activities planned for July include bingo, word games, quizzes, entertainment, trips to a concert, to a café, a quiz at another residential care facility, a visit to the RSA, as well as crosswords, reading the newspaper and cards.  Residents and families interviewed reported their satisfaction with the variety of activities available. In the 2014 resident satisfaction survey, the range and variety of activities received a high satisfaction rating. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | The service’s policy states that care plans are to be evaluated at least six monthly and more frequently if clinically indicated. Until recently, the care plan format has not included space for evaluation to be recorded on the care plan itself; this information has been documented on a separate evaluation sheet. In two of the clinical files reviewed, these evaluations could not be located. Evaluations for two other residents were very brief, and one was not completed within the required timeframes. However, the care plans for both residents had been updated to reflect changes in resident status.  The service has recently introduced a new care plan format, which now includes space for the evaluation to be documented adjacent to the interventions section of the care plan.  Short term care plans, such as when a resident was receiving antibiotics, and wound care plans, were evaluated in a timely manner. |
| 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 | Although the service has a ‘house doctor’ who visits twice weekly and on an as-required basis, residents are able to choose who will provide their medical services. The right of residents to access other health and/or disability providers is maintained. If the need for specialist services is identified, the doctor, nurse practitioner or a registered nurse sends a referral. Copies of referrals to the dietician, speech language therapist and psychogeriatric were sighted. Families and residents confirmed they were kept informed about any referrals that were being considered or actioned. Support is available to transport and accompany residents to external health-related visits, as sighted in resident records and confirmed during interviews with families. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets provided by the chemical representative were available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff interviewed reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.  Observations provided evidence that hazardous substances were correctly labelled, the container was appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled were provided and being used by staff. For example, gloves, aprons, and masks were sighted. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | One of the owners has overview of the on-site maintenance. External contractors are used for plumbing, electrical and other specialist areas. There is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. A current electrical safety tag on electrical items was sighted. Documentation and observations evidenced a current Building Warrant of Fitness is displayed that expires 11 November 2015.  Observations of the facility provided evidence of safe storage of equipment. Corridors are narrow in parts and residents were observed to be safely passing each other; safety rails are secure and are appropriately located.  External areas are available for residents and these are maintained to an adequate standard and are appropriate to the residents. Residents are protected from risks associated with being outside, including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.  Care staff confirmed they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.  Residents confirmed they know the processes to follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets 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 | All bedrooms have wash hand basins and five bedrooms have toilet facilities as well. There are an adequate number of accessible communal showers, toilets and wash hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.  Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it they vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. |
| 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 provide single accommodation. All rooms were personalised to varying degrees. Bedrooms are of various sizes and adequate personal space is provided in bedrooms to allow residents and staff to move around safely. |
| 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 | Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |
| 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 | Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.  All linen is washed on site and there is adequate dirty to clean flow. Care staff are responsible for the management of laundry. The laundry person and FM described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.  The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner was interviewed and described the cleaning processes.  Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; and appropriate facilities exist for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.  Residents and family interviewed stated they were satisfied with the cleaning and laundry service and this finding was confirmed during review of the satisfaction survey questionnaires from September/October 2014. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems were in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification were available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors were available.  A New Zealand Fire Service letter dated 1 August 2005 was reviewed and confirmed the fire evacuation scheme was originally approved on 7 December 1998. The last trial evacuation was held on 5 May 2015.  All staff have a current first aid certificate. Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.  Observations provided evidence that information in relation to emergency and security situations is readily available / displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Observations evidenced emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.  There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner. |
| 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 | Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family interviewed confirmed the facility is maintained at an appropriate temperature.  Observations evidenced that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| 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 | A registered nurse, with extensive experience in infection control management, is the designated infection control coordinator. Infection control matters, including surveillance results, are reported to the Quality Committee. Meeting minutes and reports were sighted. A sign at the entrances to the facility asks anyone who is or has been unwell in the past 48 hours to not enter the facility. The infection control manual provides guidance for staff about when they must stay away from work if they have been unwell and the duration of the stand-down period.  The service has a comprehensive infection control manual, last updated in January 2015, which guides infection control management. The manual includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator (ICC) has appropriate skills, knowledge and experience for the role, and has access to resident records and diagnostic results to ensure timely treatment and resolution of infections. The ICC advised that she is able to draw on established professional networks and links, such as the infection control team at the Wairarapa District Health Board, doctors or nurse practitioner if she requires additional information or support. The ICC last completed infection control education in 2014. Appropriate supplies of personal protective equipment are easily accessed by all staff. Additional supplies in case of an infection outbreak were also sighted. |
| 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 | A comprehensive policy/procedure manual guides infection prevention and control practices. This complies with relevant legislation and current accepted good practices. The manual was last reviewed in January 2015.  During the audit visit, staff practise was observed to be compliant with infection control requirements, including the use of aprons and gloves as appropriate. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC advised that infection control is a component of the staff orientation programme, including staff being required to demonstrate competency in handwashing. Infection prevention and control education is undertaken at least twice year, as confirmed in the annual education plan. All staff recently completed an infection control questionnaire, which requires them to demonstrate their understanding of the service’s infection control policy and processes – questionnaires sighted. The ICC also advised that additional staff education is also provided on an as required basis, such as if there was an infection outbreak or if there were an increased incidence of specific resident infections. This education is provided by suitably qualified registered nurses, such as DHB infection control specialist nurses, and the Infection Control Coordinator.  The facility manager and the ICC advised that education with residents is generally on a one-to-one basis, such as reminders about hand washing, or discussions about the importance of the annual ‘flu’ vaccine. The service is also planning to include infection control education during resident meetings. |
| 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 Coordinator develops the monthly surveillance record. This records surveillance of an appropriate range of infections, including urinary tract infections, respiratory tract infections, skin and wound infections, eye infections and gastrointestinal infections. The administrator graphs this data to demonstrate trends across time.  The monthly surveillance results are reported to the quality committee, which includes the facility manager. Surveillance results are also reported informally to staff at staff handover meetings and this was confirmed in staff interviews.  The service is planning to use an updated surveillance reporting template, which will facilitate more formal analysis of surveillance data. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The facility demonstrated that the use of restraint is actively minimised. The service uses restraint for one resident which is a bedrail. There were no residents using enablers. Interviews confirmed that enabler use is voluntary and the least restrictive option for the residents, when being used. The resident who used a restraint had this documented in their long term care plan, restraint risks were recorded and the service completed a restraint consent, assessment and approval. There were no restraint related injuries reported. Bedrails had specialised covers when in use, as part of the risk management process and this was observed during the audit.  The service had a documented system in place for restraint use, including a current restraint register. One of the RNs is the restraint coordinator and demonstrated a good knowledge of restraint procedures. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The facility maintains a process for determining approval of the restraint used. The restraint coordinator has completed a restraint assessment which was then discussed with the GP prior to commencement of restraint. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.  The duration of restraint and restraint risks; were documented in the resident’s care plan. Caregivers were responsible for monitoring and completing restraint forms when the restraints were in use. On-going education regarding restraint was evidenced, however, not all staff have received challenging behaviour education and there was no evidence of restraint competencies. (See link 1.2.7.5). Staff were made aware of the restraint use during the quality and staff meetings. This was confirmed during staff interviews and review of meeting minutes. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments included: identification of restraint related risks; underlying causes for behaviour that required restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Moderate | Before resorting to the use of restraint, the restraint coordinator utilised other means to prevent the resident from incurring injury. Restraint consents were signed by the GP, the family and the restraint coordinator. The restraint monitoring forms were completed by the caregivers; however, the form requires staff to sign when restraint is applied and when it is taken off. The form does not allow for monitoring during the time the restraint is used.  Restraints were incorporated in the long term care plan of the resident. The restraint register was sighted and was current. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint coordinator evaluated all episodes of restraint. The resident using restraint is reviewed on a daily basis, and a formal evaluation will be completed when the use of restraint reaches the three month period and three monthly thereafter. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint was still required. The resident (if able) and the family were involved in the review of the restraint’s effectiveness and continuity. Documentation was sighted in the progress notes of the resident using restraint regarding restraint related matters. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The facility demonstrated the monitoring and quality review of their use of restraints. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice was also included in their quality reviews. Staff monitored restraint-related adverse events while using restraint. Staff at interview demonstrated sound knowledge with regards to restraint processes. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | Quality improvement data is being collected, collated and graphed and reported back to staff as numbers via the quality and staff meetings. There was no evidence that data is being analysed. | Quality improvement data is not being analysed and evaluated to identify trends. | Quality improvement data is analysed to identify trends and evaluated and this information reported back to staff.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective action plans are being developed for deficits identified following incidents/accidents, audits and in meeting minutes reviewed. However, corrective actions following audits and in meeting minutes do not consistently state timeframes for completion and who is responsible for the action and sign off. | Corrective actions do not consistently state timeframes and who is responsible for the implementation and monitoring and are not signed off as being completed. | Provide evidence that corrective actions documented state the timeframe and who is responsible for implementing and monitoring, and are signed off once the action has been completed.  180 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | One of six files reviewed had documented evidence of reference checks completed and two of six files had evidence of police vetting. The FM reported they do carry out phone references; however this has not been documented. | Five of the six files reviewed did not have reference checks documented, and four of the six files did not have evidence of police vetting. | Provide evidence that all staff have reference checks and police vetting completed and documented.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | The staff files reviewed had education records that are current. The education programmes were reviewed for 2014 and 2015 and education is provided at least monthly. Competency assessments were sighted for all staff who administer medication. The majority of care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. This is provided by an external nurse educator who also is the facility’s assessor.  Twelve of the eighteen staff have not attended challenging behaviour education and clinical staff have not completed a competency assessment relating to restraint minimisation and safe practise. | Not all staff have attended challenging behaviour education and clinical staff files do not evidence restraint competencies. | Provide evidence that all staff have received challenging behaviour training and that all clinical staff have restraint competency assessments completed and that these assessments are ongoing.  90 days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | Entries are made into residents’ progress notes every shift. These entries are initialled, but it is not possible to identify the name or designation of the person making that entry.  Several clinical assessment forms, such as initial assessments and care plans, were undated and unsigned. | The names and designations of service providers making entries into the residents’ clinical records and/or completing clinical assessment documentation are not clearly identifiable and/or legible. | The names and designations of services providers making entries into resident clinical records and/or completing clinical assessment documentation are legible.  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 Moderate | In all care plans reviewed initial assessments and nursing care plans had been completed within 48 hours of the resident’s admission to the service. Full nursing care plans are required to be completed within three weeks of admission. These timeframes were not achieved for two recent admissions, and in one instance the clinical assessment that should inform nursing care plan development had also not been completed. In two of three care plans reviewed, evaluations of resident progress towards achieving identified goals had not been completed within the required six-monthly timeframe. | The development of nursing care plans, the evaluation of those plans, and the completion of clinical assessments for new residents are not completed within required timeframes. | Each stage of service provision is provided within timeframes that safely meet the needs of residents.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | A comprehensive range of clinical assessments are routinely completed promptly as part of the resident admission process with the outcomes of these assessments being used to inform the care planning process. These assessments were not completed in a timely manner for one recent admission.  The assessment of routine clinical indicators, such as residents’ weight, and vital signs (blood pressure, temperature and pulse) was irregular. For example, three residents who were in the facility for all of 2014 had those indicators recorded between four and seven times that year, instead of monthly, which is best practice. The facility manager explained that there had been problems with the weighing equipment, and new scales had recently been purchased. The care plans of two residents who had experienced weight loss over a period of time had not been updated to reflect their altered nutritional status.  Ongoing assessments related to clinical conditions, such as pain, were also erratic. The last formal pain assessment for a resident receiving regular Morphine was undertaken in September 2014. | Ongoing assessments of clinical concerns, such as resident pain, are not completed as clinically indicated. Clinical assessments such as weight, blood pressure, temperature and pulse, are completed irregularly. | The clinical status of residents is assessed / reassessed on a regular and as clinically indicated basis.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | The service’s policy requires resident progress towards meeting identified goals to be evaluated six monthly, and more frequently if resident needs change.  The six monthly-evaluations of two resident care plans could not be located.  Evaluations were sighted for two other residents, one of which had not been completed with the required timeframes. Both of these contained little information related to resident progress towards their identified goals. | Resident care plans are not regularly evaluated. Those evaluations that have been completed do not comprehensively record resident progress towards planned outcomes. | Comprehensive and timely evaluations of resident progress towards achieving desired outcomes are completed.  90 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Moderate | The restraint monitoring form used by care staff is being completed correctly. The form requires staff to enter the date, time and sign off when restraint is applied and then again when the restraint is taken off. The restraint form does not allow for care staff to enter the two hourly monitoring times following observation of the resident. | The restraint monitoring form does not allow staff to record monitoring times following observation of the resident. | Provide evidence that the restraint monitoring form allows care staff to record when they observe the resident during restraint use.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.