# Pinehaven Cottage Limited

## Introduction

This report records the results of a Certification Audit; Partial Provisional 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:** Pinehaven Cottage Limited

**Premises audited:** Pinehaven Cottage

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

**Dates of audit:** Start date: 10 June 2015 End date: 11 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:** 17

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Pinehaven Cottage provides rest home level care for up to 17 residents.

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

There was one area for improvement found related to human resources management processes.

## 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 service is committed to ensuring residents’ rights are respected during service delivery. Staff knowledge and understanding of residents’ rights is embedded into everyday practice as observed during the audit. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and families interviewed confirmed their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises their independence and reflects their wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs meet in a manner that respects and acknowledges their individual and cultural values and beliefs. Recognition and respect for all individual’s cultural, values and beliefs are provided for at the service.

Residents receive services of an appropriate standard for rest home level of care. The service provides an environment that encourages good practice.

Staff communicate effectively with residents and families with the right to full and frank information and open disclosure from the staff demonstrated. Written consent is obtained where required.

Residents are able to maintain links with their family and the community and have access to visitors of their choice.

The service has a documented complaints management system which was implemented. There was one newly received complaint which was outstanding at the time of audit. All complaints since the previous audit have been fully addressed and resolved.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The business plan informs the policy and budgeting decision making. It identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs. The purpose, values, scope, direction and goals of the organisation are regularly reviewed by the owner/directors.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified. The quality management system includes identification of hazards, staff education and training, an internal audit process, complaints management, and reporting of data related to incidents/accidents and infections. Quality and risk management activities and results are shared among staff, residents and family/whānau, as appropriate.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. This allows residents' needs to be met in a safe and efficient manner, as confirmed during resident and family/whānau interviews and in the 2015 satisfaction survey results. Human resources management processes, based on good practice, are implemented. An improvement is required to meet contractual requirements related to annual staff appraisals.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met.

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

Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry. If residents’ needs exceed rest home level of care, reassessment is conducted and the resident is transferred to a service that better meets their needs (eg, hospital level of care or secure dementia care).

The service meets the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes. The evaluation of care is conducted at least six monthly, with this documenting the resident’s response to interventions and progress towards meeting their goals.

Residents are supported to access and/or are referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and co-ordinated to minimise risks.

The service provides planned activities to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. The service has links with community organisations for activities both onsite and offsite.

The observed medicine administration process is undertaken in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertake medicine administration hold appropriate competencies.

Residents are provided with food, fluid and nutritional services that are reviewed as being suitable to meet the nutritional needs of the older person. Residents receive additional or modified nutritional requirements, special diets and food that takes into account their likes and dislikes.

## 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. |

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

The building has a current building warrant of fitness and the service has an approved fire evacuation plan.

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

Cleaning and laundry is undertaken by staff.

The facility is kept warm all year around by use of electric heating. Opening doors and windows creates a good air floor to keep the facility cool when required. The outdoor areas provide suitable furnishings and shade for residents’ use. Residents and families/whānau were happy with the environment provided.

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

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Staff undertake annual restraint minimisation education so they have a full understanding of what is required should restraint be used. The service had no restraints in use at the time of audit. There were three enablers in use to allow residents to maintain independence.

## 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. |

Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of responsibility for infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up. The service’s policies and procedures comply with relevant legislation and current accepted good practice. The service provides education on infection control to all staff, and when relevant, residents and family.

There is a monthly collection of surveillance data for infections. The surveillance data is collated and analysed, with results communicated to staff. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections. The service has clear procedures to deal with any outbreaks of infections.

## 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 | As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering residents’ bedrooms, use residents’ preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviewed across the service confirmed they respect the resident’s right to refuse cares or interventions. The interviews with residents and family members confirmed they or their family member receives services that respect their rights. The residents and families commented that one of the strengths of the service is in the manner that all staff respect the residents as individuals. |
| 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 | Signed consent forms are sighted as part of the assessment process in the residents’ files reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with residents and family members. The residents’ files reviewed have correctly signed advance directives or an advance care plan identifying the resident’s wishes related to resuscitation status and end of life care. The clinical staff demonstrated their understanding of informed consent with all aspects of care. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The residents’ files reviewed, interviews with residents and families confirmed that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family are encouraged to involve themselves as advocates and an advocate from the Nationwide Health and Disability Advocacy Service visits the service regularly. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility which family members confirm their awareness of where to locate the information.  |
| 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 | Interviews with residents confirmed they have access to visitors of their choice. The interviews with family members confirmed that they are always made to feel welcome and that staff are very friendly. The service has unrestricted visiting hours. Residents are encouraged and supported to maintain and access community services along with friends and family. Documentation sighted in residents’ files identifies that regular community outings occur and the frequency that residents go out with friends and family and the community services who visit the facility. Some community outings include weekly coffee club group, shopping trips, regular church services, school visits and entertainment. Residents are welcome to have their own spiritual advisor visit or to attended services in the community. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The sighted complaints policy, flow chart and complaints process as documented on the complaints form complies with Right 10 of the Code.Complaints management is implemented to meet policy requirements. Complaints management is explained as part of the admission process and is included in the information given to new resident and family/whānau as confirmed during interviews. Complaints management is included in new staff orientation and included in ongoing training. This is confirmed during staff interviews and in the orientation documentation sighted in staff files.Residents and families/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time. The complaints received since the previous audit have been managed within policy timeframes. There is one newly received complaint which remains open. All complaints received since the previous audit have been addressed in-house. This is confirmed in the complaints register sighted. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Opportunities are provided for explanations, discussion, and clarification about the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) with the resident and family as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service are clearly displayed at the entrance to the facility and available to residents and visitors. Interviews with residents and families reporting they are informed of their rights and that staff always respect all aspects of their rights. Staff interviewed reported they receive education annually on the Code of Rights. |
| 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 | The environment allows residents’ physical, visual, auditory and personal privacy to be maintained. All rooms are single occupancy to maintain privacy. Resident’s needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in residents’ files reviewed which shows that interventions put in place match identified needs. As observed, services are provided in a manner that maximises each resident’s independence and allows choices to be respected. The residents and families report that they are treated with respect and that residents receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect.Staff reported they receive in-service education on treating residents with respect and dignity. |
| 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 | Māori residents have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated. The manager reports there are no barriers to Māori accessing the service. The importance of whānau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interviews with care staff. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. The file of a resident, who identifies as Māori, records the resident’s iwi and describes the importance of whanau to this resident. The Māori resident’s file and advance care plan reviewed demonstrated that the resident receives services commensurate with their needs for their planned care prior to and after death.  |
| 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 | There are interpreter services available as required from the district health board (DHB). Residents receive services that take into account their cultural and individual values and beliefs. On-going resident satisfaction surveys monitor this as part the information collected. Policy identified that the resident's choice of representative is accepted by the service.Interviews with residents and family members confirmed they are consulted on their (or their relative’s) individual values and beliefs and that care is planned and delivered to meet individual needs. This covers social, spiritual, cultural and recreational needs. Families are involved in the development and review of the care plan as evidenced in the files reviewed. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff records reviewed identify that staff sign a code of conduct that identifies that the staff are required to maintain professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. Interviews with staff, residents, a general practitioner (GP), and family members confirmed they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | There is regular in-service education and staff access external education that is focused on best practice, with all educational material sighted showing evidence of being relevant to current best practice standards. Interviews with clinical staff confirmed that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures. Interviews with residents and families confirmed their level of satisfaction with all care delivery and staff attitudes. This is further supported by the results of the recent resident satisfaction survey.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Interviews with families confirmed they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family communication is clearly documented in the residents’ files reviewed, on incident and accident forms sighted and in the staff communication book. The families and residents interviewed report that communication is a strength of the service. Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | On the day of audit all 17 beds are occupied. The service has an up to date business plan which informs the decisions made in policy and budgeting. It identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs. The purpose, values, scope, direction and goals of the organisation are regularly reviewed by the owners. The quality policy statement identifies the mission of the organisation and the procedures undertaken to achieve the mission statement. Actions described include the use of quality programmes and procedures, identification of hazards, staff training and education, data reporting of incidents/accidents, infections and internal audit results to identify trends and improve services.There are four directors one being the maintenance person who is at the facility two days a week, another director, who was present during the audit, manages the accounts and payroll and is on site at least two days a week. Two directors are qualified occupational therapists, one is qualified to teach manual handling and another one is an Aged Care Education (ACE) assessor. The two occupational therapists also own and manage a second facility with offers rest home and dementia care. Two directors attend two monthly continuous quality improvement meetings (CQ I) and are available to staff as required. The day to day services are overseen by the facility manager who is an enrolled nurse (EN) who has worked at the facility for over 10 years and has held the manager role for eight years. She attends aged care association meetings and seminars, is an active member of the Waitemata District Health Board’s (WDHB) residential age care integration development group and was part of the group developing the medication guidelines for residential age care services. All members attend education appropriate to the role they undertake. Job descriptions identify management members’ experience, education, authority, accountability and responsibility for the provision of services.  Interviews with residents and family/whānau confirmed that their needs were met by the service.  |
| 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 | During a temporary absence of the facility manager the nominated second in charge, who is a RN undertakes the role with additional assistance from the directors as required. The nominated RN has many years’ experience in aged care management. The facility manager confirms she maintains close contact with and can access the directors at any time.  |
| 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 service has a business plan and quality and risk processes and plan in place covering all aspects of service delivery. Risk categories include consumer focus, provision of effective programmes, certification and contractual requirements, risk management, and continuous improvement. It identifies generalised goals and objectives, responsibilities and the measure used to identify how the controls are effective. The service is still undertaking the integration of policies and procedures from the previous owner to the new owners. This process is well managed and as each new policy or procedure is introduced staff are informed, it is discussed at monthly staff meetings and they each sign to say they are aware of any changes that are required. Obsolete policies are stored electronically by the facility manager. Quality improvement data are collected and analysed. Evaluation of data is documented and discussed at staff and management meetings. The bi-monthly CQI meeting held with the facility manager and the senior registered nurse to review planning processes and ensure residents’ needs are being met is clearly minuted. It includes a review of all collected statistical data. If a deficit is found, corrective planning occurs was identified in documentation sighted. Quality data information is used to inform ongoing improvement planning of services. The service trends and benchmarks data. It provides information to the ‘First do no Harm’ Northern Alliance falls project and the data analysis sighted showed low falls rate when compared with like facilities. Staff confirmed during interview that they understand and implement documented quality and risk processes. This included the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management.Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.Actual and potential risks are identified and documented in the hazard register. The hazard register identifies all known hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Policy states that all incidents and accidents and adverse events are recorded, investigated and analysed. This process implementation is identified in documentation sighted. The service providers fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Incident and accident reporting processes include corrective actions to be taken. Family/whānau are notified of any adverse, unplanned or untoward events at all times and confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated.  |
| 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 Low | Human resources policies describe good employment practices that meets the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation/induction programme with specific competencies for their roles, such as medication management, as confirmed during staff files reviewed. The facility manager does not have an up to date appraisal. Education records sighted identify that staff education includes on-site planned education which includes topic presented by the gerontology nurse specialist and off-site seminars and training days, such as palliative care education offered by the hospice. Topics covered support staff to provide safe, effective service provision to residents. Staff that require professional qualifications have them validated as part of the employment process and annually thereafter, as confirmed in documentation sighted. Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents’ needs are met by the service. No negative comments were voiced during interviews on the days of audit. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs and contractual requirements with the DHB. Rosters sighted identify that the sill mix is based on safe staffing levels for aged care and that staff are replaced for annual leave or sick leave. During staff interviews they verbalised that they have sufficient time and staff to complete their required duties. Additional staff are rostered to meet residents’ needs at any time. The facility manager stated she always responds to staff requests for additional staff as appropriate. Residents interviewed stated all their needs have been met in a timely manner.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses’ station and is not accessible or observable to the public. Entries into the progress notes are made each shift which records the staff member’s name and designation. The current progress notes are in a separate folder from the resident’s main file, although these files demonstrated integration of the records with the progress notes when filed in the main clinical folder. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident’s hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records. Evidence is seen in files of required data being obtained and kept confidential. This is easily identifiable and accessible for staff and other health care providers.Files that are not current are stored in a locked room on the same property as the facility. All heath care providers use the integrated file in the nurses’ station. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry criteria, assessment, and entry screening processes are documented and clearly communicated to potential residents, their family where appropriate, local communities, and referral agencies. The service offers rest home level of care. The service has a pre-entry form which identifies the resident’s required level of care. The vacancy and entry requirements are updated with the Needs Assessment and Coordination Service (NASC) at the WDHB. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Risks are identified prior to planned discharges as confirmed by interview with the RN. There is open communication between the service and families related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family or resident want discussed, these are noted on the transfer form. The specific discharge form used covers all general and specific care provision and a summary of the current care plan showing all aspects of care provision and intervention requirements and is sent with the resident as appropriate. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and a copy of any advance directives that are in place.  |
| 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 | The service implements the medicine management process according to the policy and procedures. A safe medicine administration system was observed at the time of audit. The medicines are dispensed by the pharmacy in a pre-packed system. The packs are delivered monthly, with any changes that are made by the GP delivered the same day as the change. Medicines that are not packed (eg, liquid medicines) are individually supplied for each resident. The medication packs and other non-packed medicines are checked for accuracy against the prescription by the RN when they are administered. The GP conducts a review of the resident’s medicines at a minimum of three monthly which the GP signs for on the resident’s medication chart. The service does not use standing orders. The medicines are stored in a locked cupboard in the staff office. The medicine fridge is monitored for temperature, with the weekly temperature recordings complying with guidelines. Sample signature verification is recorded for all staff who administers medicines. A review of medicine charts identifies that each medication is signed for by the GP. All prescriptions are computer generated by the pharmacy and they allow a safe medication administration process to be undertaken by staff. The prescriptions are legible, record the name, does, route, strength and times for administration. Short term medication has a start and stop date. All the medicine charts sighted identify residents’ allergies were recorded. The RN and competent caregivers are responsible for medicine administration at the service. All staff who administer medicines have a current medication competency.  |
| 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 | The menu has been reviewed by the dietitian and evidence was seen of recommendations being implemented. The menu is a six week rotational menu with seasonal variations (eg, summer, autumn, spring and winter menu). The service receives regular updates from a dietetic association, which provides best practice strategies for the provision of food and nutritional services for residential care. Every resident has a nutritional assessment review on entry to the service (and reviewed when indicated), and all residents are routinely weighed at least monthly. The cook also asks the residents what they would like for meals. There is a monthly kitchen audit that includes feedback on the quality of the meals. Interviews with residents confirmed they were satisfied with the food service and that their likes and dislikes are catered for. They reported that if there is something they do not like, there are always alternatives offered. Residents with additional or modified nutritional needs or specific diets have these needs met. The menu clearly records the choices for residents on modified diets. The diabetic or special diets are clearly specified. There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal meet current legislation and guidelines. When food is decanted from its original packaging, the food is stored in food safe containers, labelled and dated. Any food that is returned to the fridge is covered, labelled and dated. Kitchen staff have completed food safety qualifications and receive ongoing education related to their role.  |
| 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 | If entry to the service needed to be declined, the potential resident, and where appropriate their family, are informed of the reason for this and of other options or alternative services are discussed. The manager reported that where a resident has had an appropriate assessment and there is an available bed the resident would be admitted.The sighted admission agreement contains sections on the conditions in which the agreement can be terminated and changes to the level of care. The services will ensure that if the residents’ needs are no longer able to be met (eg, they require hospital level of care or secure dementia level of care) there will be an appropriate reassessment and the service will assist to find an alternative service provider and ensure the transfer occurs in a safe and timely manner. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The needs, outcomes, and/or goals of residents are identified through the assessment process and are documented to serve as the basis for care planning and service delivery. The residents’ files reviewed have assessment tools completed to develop the long term care plan and reassessment occurs at least six monthly, or earlier if there is a change in the residents’ needs. The service also utilises other appropriate assessment tools to assess each resident’s needs. These include wound assessment, pressure risk, nutrition and falls assessment. The residents reported they are involved in their care planning and consulted with changes as required.Staff reported they have knowledge of the care requirements for individual residents and changes. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long term care plan and short term care plans sighted identified the supports and interventions to achieve desired outcomes. The residents’ files reviewed identify that care planning is individualised to reflect resident’s assessed needs and interventions and support systems are clearly shown. Interventions are detailed and interviews with care staff confirmed the information ensures continuity of care. Interviews with residents, families and the GP confirmed that care is provided by staff that have excellent knowledge and skills.  |
| 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 care plans reviewed confirmed care planning is individualised and personalised to reflect the resident’s assessed needs. Additional short term care plans or clinical pathways are utilised where there is a specialised need (eg, falls minimisation and end of life care). As observed at the time of audit the care is resident centred and residents are given choices of times and type of care interventions. Interviews with the caregivers confirmed they use documented interventions to provide appropriate care for each resident. If an intervention is not working well it is reported to the RN or manager who then evaluates the resident’s progress and resources current accepted best practice to assist in resolving any issues. The residents and families confirmed they are highly satisfied with care and interventions provided by the service. Residents stated all their needs are met.  |
| 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 | Activities are planned and provided/facilitated to develop and maintain strengths, skills, and interests that are meaningful to the resident. The activities coordinator has been in her role for twelve months and also works as a caregiver. She has completed papers as part of the New Zealand Qualifications Authority (NZQA) qualifications and is supported by an occupational therapist from another facility. She also attends a local occupational therapy networking group. The group and individual activities are based on what the resident wants to do, with a strong emphasis on community activities and outings that reflect the interests of the residents. The residents’ files reviewed have activities and social assessments. The goals are updated and evaluated in each file six monthly. The activities cover cognitive, physical and social needs. The residents expressed satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Where progress is different from expected, the service responds by initiating changes to the long term care plan or by the use of short term care plans or clinical pathways. Short term care planning was sighted for infections, falls minimisation, acute conditions and wound care and confirmed in the notes of the resident reviewed using tracer methodology. The short term care plans show that the interventions are analysed, reviewed, discussed with the resident and family and evaluated for achievement towards clearly set out goals. If the interventions are not working well they are changed and staff are informed. The residents and family interviewed confirmed that they are satisfied with the care provided.The care plans evaluations sighted were documented, resident-focused, indicated the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Referrals are made to other medical services by the RN or GP as appropriate. Records of referrals were sighted in the residents’ files reviewed. Health services accessed included general medicine, surgical services, cardiology, radiology, dietitian, mental health, ophthalmology, immunology and oncology. The GP confirmed that appropriate referrals to other health and disability services are well managed at the service. |
| 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 | Policy states that all chemicals will be stored safely in designated areas. This is confirmed by observation. The risk of exposure or ingestion by residents, staff or visitors to the facility is minimised be all chemicals being kept in areas that are locked. Chemicals are clearly labelled and safety data sheets are available. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes are undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in May 2016. Maintenance is undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurs annually. Clinical equipment is tested and calibrated at least annually or when required.The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, and walking areas are not cluttered. Regular environmental audits are undertaken and any areas of concern are actively managed. If the issue cannot be eliminated then it is placed in the hazard register with action shown of how it is minimised. The service identifies planned annual maintenance and are undertaking a systematic upgrade of equipment including residents’ beds. They have recently purchased three hi-low beds to make the staff workload easier and safer. There are easily accessed shaded outdoor areas for residents which were used regularly by the residents on the days of audit. Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs. One resident survey response related to the condition of the driveway. The service have acknowledged this and state the grounds and driveway are under maintenance and slowly improving with more development coming. |
| 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 | There are adequate centrally located toilet/shower facilities for residents with separate staff and visitor facilities. Four bedrooms have toilet ensuites and all bedrooms have hand washing facilities. Hot water temperatures are monitored and documentation identifies that they remained within safe levels. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and stated that privacy is never an issue. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Dining and lounge areas are separated. The areas are appropriately furnished to meet residents’ needs. Residents and family/whānau voiced their satisfaction with the environment. As observed, activities are undertaken in one of the lounge areas.  |
| 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 | Cleaning and laundry services policies and procedures were sighted and these meet requirements.There is a dedicated storage area for cleaning equipment and chemicals. Cleaning and laundry activities are undertaken by caregivers as part of their daily tasks. Staff reported they were happy with the laundry system in use. The facility looked and smelled clean. During interview, residents and family/whānau confirmed they were happy with the laundry services provided.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management policies and procedures guide staff actions in the event of an emergency. The emergency plans take into account emergency systems, such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. Emergency education and training for staff includes six monthly trial evacuations and documentation sighted showed that no follow up actions were required following the last trial evacuation. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service. Emergency supplies and equipment includes food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and gas cooking facilities.Staff are required to ensure all doors and windows are secured after hours. Staff and residents interviewed confirmed they feel safe at all times. Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility is kept at a suitable temperature throughout the year via electric heating and the opening of doors or windows for ventilation. This is confirmed during resident and family/whānau interviews. All resident areas have at least one opening window to provide adequate natural light.  |
| 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 | The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters within the organisation leading to the senior management. The infection control coordinator is the RN and they have a job description that includes the role, responsibilities and accountability for infection matters.The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. The annual review covers quality improvements, policies, procedures, surveillance, staffing, standard precautions and education. Staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. There is a policy for staff not to come to work if they are unwell, there is a notice at the front door advising visitors not to have contact with residents if they are unwell or have been exposed to infections, and at times residents may be isolated where possible and practical. During a recent scabies outbreak there were designated chairs for residents and the van seats had protective covers. The staff interviewed demonstrated good knowledge of infection prevention and control.  |
| 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 | Evidence was seen of infections being reported on an infection report form; this information is collated monthly and reviewed and analysed by the infection control coordinator who will advise management of the outcome. The infection control coordinator reported that she has access to adequate resources to enable and support good infection control practice.The infection control meeting is incorporated into the staff meeting. The infection control coordinator communicates the monthly infection control report to the staff through monthly email notices. The infection control coordinator reports that advice was sought from the GP, DHB and infection control specialist on the management of scabies.  |
| 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 service utilises updates from an aged care consultant to review their organisational policies. The staff observed at the time of audit demonstrated good infection prevention and control techniques and the staff demonstrated good knowledge of policies and procedures for infection prevention and control.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. The infection control coordinator and specialist infection control resources are utilised for the staff in-service education. The infection control coordinator attends ongoing education on infection control, the most recent being in May 2015. The infection control coordinator demonstrated knowledge of current best practice for infection prevention and control. Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the resident. The infection control coordinator has conducted informal education with residents, such as education on the recent scabies management. The staff interviewed report they receive annual education on infection prevention and control.  |
| 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 | Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. The monthly surveillance data is collated and analysed by the infection control coordinator. The surveillance data and analysis of infections records which are the most common infections over the year; these are indicative of resident mobility and seasonal infections. The service has had a recent outbreak of scabies and there has been ongoing analysis and management of the outbreak process. The service has sought infection control and outbreak advice from the DHB and GP in the treatment and management of the scabies. The action plan for the outbreak management includes contributing factors to the event, treatment, review of systems and the environment.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policy indicates the service is committed to providing a restraint free environment. There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety.At the time of audit the service has no restraints and three enablers in use. The enablers in use (bedside loops) are to assist residents to remain as independent as possible. Each enabler is identified in the restraint register, discussed with family/whānau and signed for by the resident. All documentation completed complies with policy.Staff are aware of the difference between an enabler and a restraint and what actions need to be taken related to the use of both.  |

# 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 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The facility has an annual education calendar which identifies the education offered is relevant to the services provided. Staff can access on-site and off-site education related to aged care. Guest speakers included regular education presented by the district health board’s gerontology nurse specialist. Two of the six staff files reviewed did not have signed job descriptions (one for the cook and one for the RN) these were signed on the day of audit. The facility manager does not have an up to date appraisal.  | DHB contractual requirements D17.7f requires all staff to have annual appraisals. The facility manager does not have an up to date appraisal.  | Ensure all staff have annual performance appraisals to meet contractual requirements.180 days |

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

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

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

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

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End of the report.