

Y&P NZ Limited - Deverton House Rest Home

Introduction

This report records the results of a Surveillance 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](#).

The specifics of this audit included:

Legal entity:	Y&P NZ Limited
Premises audited:	Deverton House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 July 2015 End date: 30 July 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:	18

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

Indicator	Description	Definition
	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

Deverton House Rest Home provides rest home services for up to 21 residents. On the day of audit there were 18 residents receiving care. A registered nurse manages the facility in the role of clinical manager. All the residents and family members interviewed spoke very positively about the staff, personalised care and the standard of services received.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the district health board. Additional criteria were included in the audit at the request of the DHB portfolio manager. The audit process included a review of policies and procedures and other documentation, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed the three shortfalls from the previous certification audit around 'policy and procedures, assessing staff competency and the activities programme.

This audit identified that improvements are required in three areas relating to the admission policy/patient information brochure, evaluation of resident's progress to achieving their goals, and one aspect of medication management.

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.

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Residents and families interviewed expressed high satisfaction with the service. An interpreter was used for some interviews as eleven residents have limited English or do not speak English. Residents and family confirm communication is open and timely.

Staff, residents and family members are aware of the complaints process. Complaints are being investigated and addressed in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The organisation's vision, values and mission are documented in the business and continuity plan. There is also a documented quality and risk plan, Maori health plan, building maintenance plan and quality plan. The managing director is frequently on site, including at weekends. The clinical manager is responsible for day to day service delivery. He is experienced and participates in regular ongoing education. The clinical manager or the managing director is on call if not on site.

The quality programme includes compliments, complaints management, incident reporting and policy and procedure review. Policies are current and available to staff Document control processes are implemented and practices now meets the standards. There is a risk management plan and hazards and risks are being identified, managed and reviewed. Internal audits and surveys

are conducted with information available in both English and Mandarin. Where improvements are required following quality activities this occurs in a planned manner. The clinical nurse manager is aware of what events require reporting/notification. Monthly residents' meetings and monthly staff meetings occur.

Staff recruitment includes the applicant completing a job application. Reference and police checks are conducted. Annual performance appraisals have been completed for applicable staff. An orientation programme is in place for new employees and records of this are maintained. Staff have access to relevant ongoing education. This includes assessment of competency for various tasks. This now meets the standards.

The staffing and skill mix requirements are documented and align with the provider's contract with Waitemata District Health Board (WDHB). All except three staff have a current first aid certificate. A staff member with a current first aid certificate is rostered on each duty.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Additional criteria have been reviewed in this standard as requested by the DHB. The entry criteria documented in the resident information booklet and in policy are not congruent and this is identified as an area for improvement. Care and interventions are provided within time frames that meet the residents' needs and contractual requirements. The documented care plans are based on the assessed physical, psycho-social, cultural and spiritual needs of each of the residents. The care is evaluated at least six monthly. An improvement is required to ensure evaluation shows the achievement made by residents in meeting their identified goals. When there are changes in needs, interventions are updated and carried out as required. Staff demonstrated knowledge in providing interventions and services for the residents.

Planned activities are based on the interests and strengths of the residents.

The food and nutritional services are provided to meet the needs of the older person living in a long term care environment.

Medicines are safely administered to meet legislation and best practice guidelines. Staff who assist in medicine management are assessed as competent to perform their role. An area identified for improvement relates to who is documenting the information on the resident's medicine chart.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There have been no significant changes to the land or buildings since the last audit.

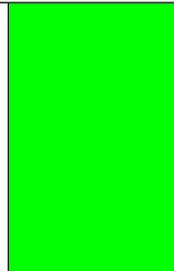
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has a commitment to a 'non-restraint policy and philosophy'. The restraint minimisation and safe practice policy and definitions comply with the standard. There was no restraint in use at the time of the audit. One resident has enablers in use. A written consent was on the resident's file. There are monthly reviews occurring to ensure/verify the use of enablers is voluntary and safe.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

Deverton House Rest Home has an infection surveillance programme that is appropriate to the service setting. Infection data is collated, analysed and trended over time. The infection surveillance results are reported at the monthly staff meetings and three monthly quality review meetings. Infection rates are benchmarked with other facilities.

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 Standards applicable to this service 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	18	0	3	0	0	0
Criteria	0	42	0	3	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The service policy states the Code is displayed and available to all residents and monitored to ensure the rights of residents are respected. New residents and family are given a copy of the Code on admission and a copy is displayed on the wall in full view for residents, caregivers and visitors in both English and Mandarin. On commencement of employment all staff receive induction/orientation training that includes residents' rights and their implementation.</p> <p>The staff interviewed demonstrated knowledge on the Code and how resident's rights were to be met in their day to day practice. This was observed during audit. All residents and family members interviewed confirmed staff treat the residents with respect, their privacy is maintained, and the resident is given choices about day to day activities. This criterion was included at the request of the DHB.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>The complaints policy detailed the residents or family member's right to make a complaint. The process for reporting, investigating, documenting and following up the complaint is documented and the timeframes aligned with the requirements of the</p>

<p>understood, respected, and upheld.</p>		<p>Code of Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The clinical manager advised there have been three complaints received to date in 2015. A complaints register is being maintained. One complaint was recently received via the DHB. This is still under investigation at the time of audit. The clinical manager advises there have been no known complaints to the Health and Disability Commissioner (HDC) or the Ministry of Health (MOH) since the last audit. A review of two of the complaints verified the complaints have been investigated and responded to in a timely manner. A family member was interviewed in relation to the complaints. The family member confirmed that the two complaints were investigated by Deverton House Rest Home managers and responded to in a timely manner. The complaints have been fully resolved to the resident and family's satisfaction. All other residents and family members interviewed on this topic confirmed they were aware of the complaints process. The residents and family members stated they are very satisfied with staff and the services provided.</p> <p>The staff and clinical manager interviewed were able to detail their responsibilities in the event a resident made a complaint.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>As observed on the day of audit and confirmed with review of the residents' files, residents receive services in the least restrictive manner. Policies and procedures detail what abuse and neglect is, and staff responsibilities if they suspect a resident is at risk of abuse or neglect. Staff interviewed are able to describe their responsibilities. The residents and family members interviewed expressed no concerns whatsoever in relation to abuse or neglect and reported that staff are always caring and kind. This criterion was included at the request of the DHB.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The DHB requested review at audit of the number of residents who do not speak English and how communication occurs to meet their needs.</p> <p>Eleven of the residents speak very limited or no English. The clinical manager is able to speak both Cantonese and Mandarin and can communicate with the residents directly. There are a number of caregiving staff that speak Mandarin and/or Cantonese and English and other staff who speak English only. A review of the roster identified that during the morning and afternoon shifts there is often a Mandarin speaking staff member and an English speaking staff member on duty. The residents</p>

		<p>and family members interviewed were satisfied with communication processes. They noted on infrequent occasions they may need to use gestures or body language to convey their needs, but are unconcerned about this. The clinical manager advises interpreters would be sought from the DHB if required.</p> <p>The family members interviewed (including some interviewed with the assistance of an independent interpreter) confirm that staff communicate with them in an open and timely manner. The family members confirmed being advised of residents' falls, infections, changes in medications, wounds or other 'issues'. Evidence of open disclosure and family communications is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes. The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed.</p> <p>A number of documents have been translated into Mandarin including the various satisfaction surveys and the signature page of the admission agreement. These documents were reviewed by the independent translator who noted there is an occasional word missing in the Mandarin version which reflects the change from oral to written translation. Some of the information 'could have been clearer' however, confirmed the translated versions were 'not misleading'.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business and continuity plan details that Deverton House Rest Home provides a service for those who cannot live independently and who are needing 24 hour rest home care. The plan notes services are provide that are culturally appropriate, individual, goal-orientated, with purposeful programmes and social interaction that contributes to a resident's independence. The values, vision and philosophy is detailed in the resident's admission pack. This has recently been reviewed (July 2015) and has been discussed with the staff and revised. The clinical manager is in the process of updating the other organisation documents that includes or references these statements.</p> <p>This facility is one of three facilities owned by the managing directors. Each facility has a manager.</p> <p>The clinical manager advises monitoring of progress to achieve the business and continuity plan occurs by reviewing the results of the quality and risk programme, through resident and family feedback and through discussions at the three monthly quality review meetings. The meeting minutes sighted verified a regular process of</p>

		<p>reviewing how the organisation is progressing to meet the goals.</p> <p>The clinical manager works three days a week on site (Monday, Wednesday and Friday) and is on call when not on site. The clinical manager was previously the registered nurse (employed in April 2014) and was appointed to the role of clinical manager in May 2015. This clinical manager has worked in other aged care services in New Zealand and critical care services in both Hong Kong and the United Kingdom. The roles and responsibilities for the manager is detailed. The clinical manager attends regular education relevant to the role and has attended more than eight hours of education related to managing an aged residential care service in the last year, as required by the provider's contract with WDHB.</p> <p>The managing director and spouse come on site almost every day (including weekends) as stated by staff, residents and family members interviewed, and are available to residents and family members at any time.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Policies and procedures are available to guide staff practice. The policies have been developed by an external consultant and then personalised to reflect the needs of Deverton House Rest Home. All the policies have been reviewed by the previous manager between November 2014 and May 2015 and are available for staff. Document control processes are implemented. The shortfall identified at the last audit has been addressed.</p> <p>There is a documented quality and risk plan sighted. A review of the quality and risk programme is undertaken via a quality and service review meeting. Topics discussed include hazards/risks, the results of audits, infection data, use of restraints/enablers and the number and type of reported incidents. Deverton House Rest Home benchmarks a number of aspects of care with other residential aged care facilities. A significant reduction in resident falls has been noted in 2015. Restraint is not used. One resident has an enabler.</p> <p>Internal audits have been undertaken and are conducted using template forms. A schedule is present detailing what audits are to be completed and when. All audits scheduled between January and July 2015 are noted as having been completed. The nine audits sampled confirmed there is good compliance by staff in meeting the requirements of the policy and audit criteria. Where improvements were required these improvements have been documented and implemented.</p> <p>A resident satisfaction survey was conducted in the last three months. The results</p>

		<p>were very positive. A separate food satisfaction survey, complaints survey and activities/recreation survey has also been undertaken in March and April 2015. The satisfaction surveys and complaints surveys are available in English as well as Mandarin. The feedback is positive from residents and any individual requests have been noted and followed up.</p> <p>Resident meetings have been held monthly and between ten and twelve residents attend. Minutes sighted reflected discussion on activities, infection prevention, activities/outings, food services, cleaning, laundry services and special occasions. Follow up of any actions undertaken in response to discussions occurs both one week and four weeks after each meeting.</p> <p>Staff meetings are held monthly. The minutes of the last three meetings were reviewed and included information on audit results, incidents/accidents and changing individual resident's needs, residents who have developed an infection, policy/processes, staff training/education and other issues relevant to the service. Staff interviewed confirmed they are kept informed of quality and risk issues in a timely manner.</p> <p>Staff are required to report any hazards. Where hazards/maintenance concerns have been identified these have been eliminated or minimised.</p> <p>A risk management plan is in place. Organisation risks are categorised. The plan includes the identification of the hazards/risks, risk reduction strategies, readiness, response and recovery activities. The risk and hazard plan has been reviewed in January 2015.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>The clinical manager has developed a new reporting form for accident and incidents. One form is now used to report incidents/accidents (IAs) rather than different forms per type of event as occurred previously. The new IA form is used for the reporting of staff/visitor injuries, falls, hazards, skin tears/lacerations, sprain/bruises, pressure ulcer medication problems/errors, security events, equipment/building issues, residents with infections, challenging behaviour, complaints/compliments, resident admission to hospital, residents who are admitted or transferred to another facility and other events.</p> <p>The clinical manager has developed an electronic reporting programme that enables details of an incident/adverse event to be entered once into the patient record. The information is automatically populated to the monthly register per type of</p>

		<p>incident/accident, as well as updates a list of any reportable events per resident. The individual resident's risk assessment profile is also updated. The clinical manager can easily review individual events as well as to have a systems focus for reportable events. The clinical manager demonstrated how the programme works. The data also links to the patient handover form and automatically updates the handover form with details (e.g., of the resident's most recent fall). The information on the handover sheet aligned with the incident reports sampled. This programme is continuing to be refined. The caregivers interviewed stated the new process has made handovers clearer. Short term care plans are developed following reported events and these are regularly evaluated.</p> <p>Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This is verified by resident and family members interviewed who confirmed they are always kept informed. The IA form includes an area to record who was informed about the event and includes notification where applicable to the clinical manager, the resident's GP and family members. The rate of residents' falls has reduced by over 50% in comparison from 2014 and 2015 data (pre and post change period). In the 2105 (January to July year to date) no resident is noted to have fallen more than once.</p> <p>An increase in medication related events has occurred in 2015, following change in the pharmacy supplier. The managing director has addressed this with the supplier directly. Improvements in this service have been noted.</p> <p>The clinical manager is able to identify the type of events that must be reported to external agencies. One notification has been made to HealthCert in May 2015 detailing the change in manager.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The copy of the annual practising certificates (APCs) for the two general practitioners (GPs), clinical manager, dietitian, podiatrist and pharmacist was sighted.</p> <p>The recruitment/employment policy aligns with current accepted practices. This includes staff completing an application form, police vetting, interviews being conducted and reference checks obtained. Staff have a signed employment agreement and confidentiality/privacy agreement on file. Performance appraisals are conducted at least annually and these were sighted in staff files sampled where the employee has worked at Deverton House Rest Home for more than 12 months.</p> <p>Records evidencing completion of the orientation programme were present in staff</p>

		<p>files. The new employee's responses to questions in the induction booklet have been reviewed. Staff interviewed report the orientation included one or two shifts being 'buddied' with a senior staff member. The orientation included the facility, policy/processes, facility routine, quality and risk programme, complaints process, infection prevention and control, staff tasks, and the individual resident's care needs.</p> <p>Ongoing education is planned and provided for staff. The training plan for 2015 was sighted and includes topics to meet these standards and the provider's contractual obligations with Waitemata DHB. Records of attendance are being maintained and a summary sheet monitors who attends what in-service education. Copies of certificates are present in the five staff files reviewed. In-service education and attendance records were sighted showing staff had access to regular ongoing education relevant to their roles and the service. Competency assessments were completed in 2014 and repeated in 2015 for health care assistant staff to undertake activities including weighing residents, check blood glucose levels, monitor vital signs and administer medications. The shortfall identified at the last audit has been addressed. These assessments have been undertaken by the registered nurse or clinical manager. Documented instructions have been provided to staff in the two weeks prior to audit to clearly identify what vital signs must be reported to the clinical manager. This document is displayed in the nursing station. Two caregivers interviewed, when given examples of vital signs could detail which ones must be reported to the clinical manager. The caregivers were aware of this new document.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with Waitemata District Health Board (WDHB).</p> <p>The current roster was reviewed and demonstrated that there is at least one 'senior' caregiver on each shift. On morning and afternoon shift a second caregiver is rostered for shorter hours except for the weekends where both morning caregivers work a full shift.</p> <p>The residential care officer works weekdays between 9 am and 5pm and is responsible for activities and management duties if the clinical manager's is not onsite. The managing director is also noted to be on site on Tuesday, Thursday and on the weekends. Family and residents interviewed advised the managing director and spouse are present on site more frequently than this. The managing director's spouse undertakes facility/maintenance tasks and also assists with transporting residents off site when required.</p>

		<p>The clinical manager is noted on the roster to be on site Monday, Wednesday and Friday between 8 am and 3pm. The clinical manager is on call when not on site. The clinical manager also works in one of the other rest homes owned by the managing directors and advises occasionally will change the hours on site if a resident at either of the facilities is unwell or he is attending education. The clinical manager and staff advise in this event the clinical manager comes onsite other hours. This aspect was reviewed at the DHB request.</p> <p>Additional staff hours are rostered for the kitchen service (6.30 am to 2 pm) seven days a week, and cleaning services (9 am to 1.30 pm weekdays). Additional hours are allocated for the laundry services.</p> <p>All caregivers interviewed report that there is sufficient staff available and that they are able to complete their work. The staff confirmed the clinical manager and the managing director is available out of hours if required. The managing director is also an experienced caregiver. At least one staff member on each shift has a current first aid certificate and these were sighted.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>PA Low</p>	<p>The service has admission information packages for potential residents which identifies that all residents must have a needs assessment undertaken to show that they are rest home level care. Entry screening criteria are clearly communicated to people who seek entry to the service. During interview with residents and family/whanau members they confirm that entry to the service was undertaken in a timely and respectful manner and that they were communicated with in a manner they clearly understood. This was confirmed via use of an interpreter for non-English speaking residents and discussions with English speaking residents on the day of audit. (This meets criteria D12.4 of the ARRC contract that residents have received advice about their right to receive a NASC assessment).</p> <p>All 18 residents have a signed admission agreement to meet clause D13.1/2 and services being charged for D16.4 of the ARRC contract. This information varies and is an area identified for improvement.</p> <p>During discussion with management it was agreed that the RN is the person who makes the final decision about who is accepted into the facility.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Medicines are delivered from the pharmacy in pre-packed dispensing systems. A safe medicine management system that complies with legislation and aged care safe practice guidelines was observed. Medications are securely stored and there is correct secure storage available for controlled drugs. The service has no controlled drugs at the time of audit and there are no standing orders. All medications are individually prescribed and dispensed in the pre-packed system. Each medicine prescription and medication record has the required information and detail to comply with legislation, however the medicine forms are printed at the facility and not provided by the pharmacist. Medication reviews have been documented at least three monthly on the medication charts.</p> <p>There are three residents who self-administer some of their medications. Two residents administer their own eye drops and one resident uses their inhaler. Staff state they observe the self-administration. This is confirmed during interview with two residents who undertake self-administration.</p> <p>All staff who assist with medication management are assessed as competent to do so upon commencement of employment and annually thereafter.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The four week rotational menu, with seasonal variations, was last reviewed in February 2015 by a registered dietitian to ensure the menu is suitable for older persons in aged care. The menu allowed for cultural differences to be recognised. One residents meeting identified that non-Asian residents would like larger meal sizes. This has been followed up via the corrective action process and no negative comments were made regarding food on the day of audit. Residents are routinely weighed monthly or more frequently if there are any concerns with unexpected weight loss which was the case with the resident reviewed in detail using tracer methodology. The resident was weighted weekly and this information is shared with the GP.</p> <p>The kitchen service is made aware of each resident's nutritional profile. Residents with additional needs or special diets have this recorded on the white board in the kitchen; this includes likes and dislikes. Specific interventions for unexplained weight loss are implemented and clearly shown on the resident's dietary profile, care plan and in the kitchen. Residents are asked each day what meal option they would like. The residents reported satisfaction with the meals and fluids provided. (Specialist dietary supplements are charted on the resident's medication chart and this process</p>

		<p>is overseen by clinical staff.)</p> <p>All aspects of the kitchen services meet current legislation. All kitchen staff have food safety training. The observed preparation, serving and storage of meals comply with food safety guidelines.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All assessments are undertaken using either interRAI or an approved paper based assessment tool, such as pain scale, as required. The assessment process informs the care planning process. The care plans sighted accurately reflected the assessed needs of the residents. The assessment processes sighted in the residents' files reviewed covered the resident's individual physical, psycho-social, cultural and spiritual needs.</p> <p>Interventions are communicated to staff via handover processes and staff confirmed they can understand the care plan documentation. Family/whanau are informed and encouraged to be involved in care planning as identified in the communication sheet located in each file reviewed and confirmed during interviews. Referral processes to other health care providers are documented and followed as shown in the file used for tracer methodology.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The service has fully implemented the use of the interRAI assessment and uses their own care plan format. All the care plans reviewed evidenced individualised care plans that reflected each resident's needs. The care plans reviewed demonstrated service integration. The resident's files have one main folder that contains the medical information, nursing assessment, care plan, activities, therapies, correspondence and specialist consultations. There is a specific file containing routine observations such as weights, blood pressure and oxygen saturations and when they are due. All care plans sighted are up to date and with the interventions described so set goals can be achieved. Staff are able to verbalise their understanding of policy and procedures related to residents' care needs and confirm they always contact the RN on call if they have any concerns.</p> <p>Following a recent complaint, as a quality improvement, the service has put very clear parameters around what staff should do if a recording, such as blood pressure, is not within the currently accepted best practice normal limits. Interviews with caregivers confirmed they understand what is required and that any variances must be reported</p>

		<p>to the RN.</p> <p>The residents and family/whanau interviewed reported that they are happy with level of care offered and that their needs are being met. The GP interviewed expressed satisfaction with the care provided and confirmed all his instructions are followed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. Consultation and liaison with specialist services is identified in the residents' files reviewed. Examples include the wound care nurse specialist and mental health services for older people. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whanau interviewed reported satisfaction with the care and service delivery.</p> <p>Management report that if a resident requires a higher level of care than rest home care, referrals are made to the needs assessment agency for this to occur. A resident has recently moved to another rest home to be nearer family.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>An area identified for improvement from the previous audit has been fully addressed by the service. Resident meeting minutes confirm that any concerns voiced are followed up and outcomes are reported back at the next meeting. The residents were observed participating in planned activities. There are planned activities undertaken by the residential care officer five days a week, with caregiving staff and the owners providing activities on the weekends. The monthly resident meetings are used to gain feedback about the planned activities undertaken to ensure they are meaningful to the residents.</p> <p>The residential care officer reported the activities are modified according to the capability and cognitive abilities of the resident, with examples given of how activities have been modified for residents from various cultures. Activities assessment was sighted in all residents' files reviewed. This covered physical, social, recreational and emotional needs of the resident.</p> <p>Residents are encouraged to contact friends and family/whanau via Skype. Religious beliefs are catered for by regular church services on-site, visiting church members to support residents and residents attending off-site church groups of their choice. Cultural support includes celebrating special days related to a resident's ethnic origin, such as Easter and Chinese New Year.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Evaluations are recorded on the care plan; however not all documented evaluation of care describes how the resident is progressing towards meeting their goals. This is only an issue for residents who have had no change of interventions between evaluations.</p> <p>Where progress is different from expected the service uses a short term care plan to identify and record these temporary needs. If the change is ongoing, this is recorded and updated on the long term care plan. Short term care plans sighted in the files reviewed have detailed evaluations.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness with an expiry date of 27 July 2016. There have been no significant changes to the building since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and service and is described in the infection control programme. All staff are required to contribute to the surveillance activities. The caregivers interviewed could detail the signs and symptoms that would be reported to the clinical manager and/or general practitioner for review. Short term care plans are developed when a resident has an infection and staff advise the plan of care is discussed during the shift handover.</p> <p>There is a monthly infection surveillance report. The surveillance programme includes (but is not limited to) urinary tract infections (UTIs), eye infections, upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea, vomiting, and oral/throat infections. The monthly analysis of the infections for January to July 2015 was sighted. The three most recent monthly staff meeting minutes and the quarterly quality review meeting minutes were also sighted. The minutes reflected discussions on individual resident's needs as well as infection numbers, types and trends.</p> <p>The surveillance data is benchmarked with other residential aged care facilities via an independent contractor/advisor. There have been no outbreaks since the last audit. The infection rates are low.</p> <p>Residents are offered an annual influenza vaccination.</p>

<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has a commitment to a `non-restraint policy and philosophy`. The restraint minimisation and safe practice policy complies with the standard. There was no restraint in use at the time of the audit. One resident has an enabler (bed loop) in use to aid mobility and independence. An enabler register is maintained.</p> <p>Staff interviewed had a good understanding that the use of enablers was a voluntary process to aid freedom of movement. Signed consent forms are on file for the resident with an enabler in use. The resident care plan includes the use of enablers. A monthly review of enabler use notes that enablers are being used appropriately and safely.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	<p>The information package related to entry to the service covers a wide range of services offered and includes the Code of Rights, emergency management, complaints/concerns process, privacy, advocacy, the service vision and philosophy and any charges not covered under the Age Related Residential Care (ARRC) contract such as hairdressing. During interview residents and family/whanau confirmed the information in the admission pack was explained and discussed with them prior to entry to the service. The information differed between the policy and the resident's information pack. The RN reported that one short stay resident entered the service without a needs assessment. Prior to accepting the resident the RN checked that this could be done,</p>	<p>There is conflicting information around what items are paid for by the service. For example, the resident information pack states that continence products are paid for by the service but in policy this states private paying residents may be charged for this. Management confirmed that no additional charges have been passed onto any resident. The resident information brochure advises a needs assessment is required, while the policy does not explicitly detail this.</p>	<p>Ensure that the documented information contained in policy and in the entry information booklet given to people who make an enquiry are congruent.</p> <p>180 days</p>

		<p>and provided the information he was guided by which he had downloaded from the Ministry of Health website, relating to criteria for entry into residential care for private paying people.</p> <p>No further investigation could occur during this audit to verify this admission process as all documentation had been removed from the facility by the DHB as part of a complaint process being investigated.</p>		
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>The medicines management system described in policy is implemented by the service. This includes dispensing, administration, review, storage, disposal and reconciliation processes which comply with legislation, protocols and guidelines. The RN has developed a system where prescribed medication is typed up at the facility. Whilst each entry is reviewed and signed off by the GP the medicine form needs to be written up by the GP or the pharmacist to ensure legislation is being complied with.</p>	<p>The registered nurse has typed out and printed the medication charts for every patient. Each entry on each medicines chart has been reviewed and signed by the general practitioner. This is a form of transcribing and if the service wishes to have a typed form; this is the role of the pharmacist. This was discussed on the day of audit with the RN who will follow up with the pharmacist.</p>	<p>Ensure all legislative and best practice processes related to safe medicine management are complied with.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>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.</p>	PA Low	<p>Evaluations are noted within the required timeframes. If there are changes made to a resident's interventions owing to poor progress towards meeting a desired goal the newly developed interventions and outcome are clearly documented and evaluated. If there has been no change in the resident needs the degree of achievement or response to the</p>	<p>Evaluations are noted within the required timeframes but do not always indicate the degree of achievement or response to the interventions. For example the word 'no change' is used if the care planning needs have not changed. This does not show any measurement against goal</p>	<p>Ensure all evaluations indicate the progress the resident is making toward achieving the documented desired outcome.</p> <p>180 days</p>

		interventions is poorly indicated.	achievement.	
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.