# Sunflower Field Trading NZ Limited - Summerville Rest Home

## Introduction

This report records the results of a 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Sunflower Field Trading NZ Limited

**Premises audited:** Summerville Rest Home

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

**Dates of audit:** Start date: 29 October 2015 End date: 29 October 2015

**Proposed changes to current services (if any):** Change in ownership, which is provisionally scheduled for 10 November 2015.

**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.

## General overview of the audit

Summerville Rest Home provides rest home services for up to 17 residents. On the day of audit, there were 13 rest home residents.

This provisional audit was conducted against the relevant Health and Disability Standards and the agreement with the Hawkes Bay District Health Board due to the proposed sale of the business. The audit process included a review of policies and procedures, a review of resident and staff files, observations, and interviews with residents, families, staff, the current and prospective provider and a general practitioner.

The prospective provider is a non-New Zealand registered medical practitioner. He is currently managing an aged care residential service in Whangarei and will act in a governance role. He has developed a transition plan and intends to make no changes to the existing staffing arrangements, quality systems or the environment, in the immediate future. He plans to operate the rest home in close consultation with the existing facility manager and the registered nurse.

Improvements are required regarding the reporting of suspected outbreaks of infection; the management of records for current residents; ensuring residents are seen by a general practitioner in a timely manner; medication documentation and management; and calibration of medical equipment.

## Consumer rights

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (i.e., the Code) are in place. Posters on the Code are displayed in the facility. Information about the Code and services are readily available to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented. There is a Māori Health Plan and implemented policy supporting practice. Residents and family interviewed verified that their rights are respected.

## Organisational management

The current and prospective governance arrangements were considered. The prospective owner intends to retain all existing staff including the facility manager and the part-time registered nurse. The facility manager has been employed by Summerville for 25 years. The facility manager and the registered nurse manage the onsite and on call commitments. There is an implemented quality improvement plan. Key components of the quality improvement plan link to the staff meetings. An annual resident/relative satisfaction survey is completed and there are quarterly resident and relative meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme in place that provides new staff with relevant information for safe work practices. There is an in-service training programme covering relevant aspects of care and support. The facility staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

Residents and families receive a comprehensive welcome booklet on admission. The registered nurse completes initial admission assessments and risk assessment tools. Care plans are developed in consultation with the resident and/or family input. Short-term care plans are used to document changes to health status. General practitioners review residents three monthly or earlier as required. All care staff are responsible for administration of medicines. All residents have an individual activities plan and a group activities programme is in place. The group activities programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. Residents and relatives interviewed expressed satisfaction with the care provided. The caregivers prepare all food on-site. Residents’ nutritional needs were identified and documented. Residents commented positively on the food service.

## Safe and appropriate environment

The facility has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored safely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are adequate numbers of communal toilets and showers within the facility. There are two lounges and a dining area, which are easily accessible. There is a designated laundry and cleaner’s room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are accessible with suitable pathways. Seating and shade is provided.

## Restraint minimisation and safe practice

There were comprehensive policies and procedures in place that met the restraint standards. There was a restraint coordinator with delegated responsibilities for monitoring enabler/restraint use and compliance of assessment and evaluation processes. Enabler and/or restraint use was discussed at staff meetings. There were no residents using enablers or requiring restraint at the time of audit.

## Infection prevention and control

The infection prevention and control programme includes policies and procedures to guide staff. The registered nurse is the infection prevention and control coordinator. An infection prevention and control register is used to document infections. A monthly infection control report is completed and analysed. There has been one outbreak of suspected gastroenteritis infection since the previous audit in September 2015, which involved residents and staff, which was not reported to external authorities as it was not recognised as an outbreak.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 39 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 84 | 0 | 6 | 3 | 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 | The service has documented consumer rights policies and the Health and Disability Commissioner’s Code of Rights posters are displayed in the facility. On interview two caregivers, the registered nurse (RN), and the facility manager were aware of residents’ rights and were able to explain how they incorporated this into their practice. Five residents interviewed stated that their rights are respected. One family member interviewed spoke highly of respect for all aspects of the resident’s rights. |
| 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 | There are established policies and procedures around informed consent and advanced directives. There are signed consents in place in the five resident files sampled. Advance directives are documented and staff interviewed reported that the directives are acted on when appropriate. Copies of the enduring power of attorney (EPOA) were available in resident files sampled where applicable. Discussions with the facility manager, the registered nurse and two caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal cares. Discussions with residents confirm that staff seek permission prior to providing cares.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with two caregivers and the RN and facility manager confirmed that they are aware of advocacy and how to access an advocate. |
| 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 | Discussion with staff, residents and family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church and community groups. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission and available in the service entrance. Interview with five residents and one family member confirms an understanding of the complaints process. There is a complaints register. Discussions with two caregivers and the RN stated that concerns/complaints were discussed at staff meetings and this was verified on meeting minutes reviewed. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | On entry to the service, residents/family receive an information pack that includes code of rights information and a resident admission agreement. There is a separate admission agreement for short-term resident’s that reflects the short-term agreement. The manager or registered nurse (RN) discusses the information pack with the resident and the family/whānau on entry. This includes the code of rights, complaints and advocacy. Health and Disability advocacy service leaflets are available to residents and family in the service entrance. On interview with two caregivers, they described how they take time to explain the rights to residents and their family members. Residents interviewed confirmed that they had received information about their rights on entry to the service.The prospective director confirmed in interview that he is committed to ensuring residents receive services in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' 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 service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. There are clear instructions provided to residents on entry regarding responsibilities related to personal belongings in their admission agreement. Caregivers interviewed were able to provide examples of how they maintain privacy and dignity for residents. Privacy and dignity training was provided in 2015. Residents and family members interviewed stated they felt their needs, values and beliefs were respected. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The importance of whānau is documented in the Māori health policy. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. There are guidelines for the provision of culturally safe services for Māori residents and cultural awareness and these include guidelines around the importance of whānau. One resident identified as Māori on the day of the audit.  |
| 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 | The service provides a culturally appropriate service by including cultural needs as part of care planning with family/whānau involvement when available. Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Family are involved in assessment and the care planning process.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There is an abuse and neglect policy in place. Residents interviewed reported that the staff showed respect. Elder abuse and neglect training is included in the annual training plan and was last provided in May 2015 with good attendance. Staff contract agreements include harassment and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service has policies to guide practice that aligns with the health and disability services standards. The manager and RN review all policies annually. Staff sign off when they have read all policies. There is a quality improvement plan that includes performance monitoring and an internal in-service training programme. There are established links with the local hospice education and the manager assists with palliative care education, as palliative care is offered to long-term residents. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy, which describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the code of rights. This information is discussed. The information pack is available in large print and advised that this can be read to residents. Residents and family interviewed praised the communication from the management team. Discussions with two caregivers identified their knowledge around open disclosure. Formal resident meetings are documented quarterly. The activities coordinator holds weekly ‘tea and chat’ meetings with residents, which allows the residents to voice concerns in an informal setting. Management meetings document that these concerns are discussed and resolved. Annual resident and relative surveys are also completed.The prospective provider intends to meet with all residents and relatives and continue existing communication strategies. The prospective purchaser speaks Mandarin and Cantonese languages. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerville Rest Home provides rest home level care for up to 17 residents. Services are provided under the aged residential care agreement and the respite care agreement with the DHB. On the day of the audit there were 13 residents including one respite resident. The service has a documented quality improvement programme that includes the quality philosophy and quality improvement plan, which is reviewed annually.The facility manager has been in the role for 16 years and has been employed at the facility for the last 25 years in a variety of roles. She has a certificate in management. A RN who has been employed this year and who works 8 to10 hours a week, supports her. The prospective purchaser intends to make no changes to the existing employment arrangements of the facility manager and the RN. All other existing staff will be re-employed by the prospective purchaser under the same terms and conditions of employment.The prospective purchaser is employed full-time in Whangarei as a facility manager of a 21 bed rest home. He is a non-New Zealand registered medical practitioner. He has recently completed health care training at Unitec. The prospective purchaser does not own any other aged care residential facilities in New Zealand. The prospective purchaser will assume the role of managing director only. He will work with the facility manager to manage payroll and other financial aspects of the business in consultation with the company accountants. The current owner is contracted to provide support for two weeks from the date of purchase and there is a transition plan in place which identifies current and anticipated organisational risks. The managing director intends to manage the business remotely, and will be supported onsite by the facility manager and the registered nurse.  |
| 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 manager, the RN and/or the current owner provide leadership and take over the management role. The prospective provider intends to make no changes to the established plans for service management, such as determining who will cover when rostered staff are absent and managing staff change. The RN will provide cover in the immediate absence of the manager. If the manager is away for any length of time then the prospective purchaser will implement alternative arrangements. |
| 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 | A quality improvement programme is in place that is ongoing with objectives, action plans, responsibilities and date/timeframes. The manager and owner both manage the quality system with support from the RN. There are a range of policies, associated procedures and forms in place. Policies have been updated to include reference to InterRAI LTCF procedures. The monthly staff meetings include quality assurance discussion, internal audit outcomes, health and safety, infection control, complaints and restraint as needed. The minutes of these meetings are documented and include feedback from the quality meeting and a six monthly review of internal audits. There are also weekly management meetings. The service has four resident meetings a year and informal resident meetings once a week with the activities coordinator, who takes and actions minutes. There are annual satisfaction surveys to encourage resident and family participation. The surveys have been reported back to staff and quality assurance meetings with evidence of changes made because of survey feedback. There is a wall planner with a schedule of internal audits. Corrective action format is used for audits, meeting minutes and reports. The service reviews all audits six monthly and action plans are followed up through staff and quality assurance meetings. Incident and accident reporting and health and safety are all linked to the quality and risk management system. There is a risk management register. Risks are monitored through implementation of quality activities and reviewed though meetings. The prospective purchaser will use the existing annual quality plan until it expires in 2016. The internal audit system will continue without change. There are no plans to change existing operational (management and clinical) policies or procedures, except for relabelling the policies with the prospective purchaser’s name and logo where applicable, as specified in the transition plan. The quality management system will be maintained by the facility manager and the registered nurse and will continue to use the existing systems. |
| 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.  | PA Low | There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise, and debriefing. The service collects incident and accident information. The reporting system is reported and monitored though staff meetings, quality assurance meetings and management meetings. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. Incident forms are retained on the resident file for one month to alert staff to the incident and then they are filed. A review of ten incident forms from August, September and October 2015 document that families have been informed of adverse events.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. All employment contract documentation is stored off-site and was not able to be audited. Other employment documentation was held on-site. The practising certificate for the RN was sighted and was current. The service maintains copies of other visiting practitioner’s certification including the general practitioner. Five staff files were reviewed including the files of two caregivers, the RN, the activities coordinator and the manager. The RN has been InterRAI trained. There is an annual appraisal process in place and appraisals are current in the five files reviewed. New staff complete an orientation that was sighted in the files reviewed. The service has a training schedule for in-service education. The in-service schedule is implemented and attendance recorded at sessions kept, each session includes an attendance sheet. Interview with caregivers indicated there is access to sufficient training. The prospective purchaser advised they will complete new employment contracts for all staff and contracted providers. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a policy on staff numbers and skills. Skill mix is reviewed on a regular basis and reviewed in-line with resident numbers. There is a management of staff shortages policy. There are two caregivers on duty in the morning, one full and one ‘tea’ shift in the afternoon and one caregiver overnight. The manager is on site from 7 am until 3 pm Monday to Friday and on call if not on-site. The current owner is on site during the week and there is a RN on site for 8 to 10 hours per week who is also employed at another aged care facility in the area. Roster shortages or sickness are covered by casual or off-duty staff. The caregivers interviewed report that there is sufficient staff cover. The prospective provider advised they will re-employ all existing staff under the same terms and conditions of employment. The prospective provider will continue to operate the existing policy regarding staff skill mix and staff according to contractual obligations taking into consideration the acuity of consumers within the service. There are no changes planned to the existing staffing arrangements. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | Prior to entry to the service residents are assessed by a needs assessment and service coordination agency. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. The RN conducts InterRAI assessments. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Residents’ files are integrated and they include GP input and reviews.Resident files are stored securely and protected from unauthorised access. Only relevant personnel can access records. Care plans and progress notes are legible and signed by staff making the entry. Medical notes are signed and dated appropriately. A shortfall was noted around documentation. |
| 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. | PA Low | There is an admission policy and associated procedures and forms in place. There is a welcome pack that includes a copy of the service agreement, which is given to all prospective residents on inquiry. The service has a long-term admission agreement and a short-term agreement for respite residents. The admission agreements are based on the NZ Aged Care Association’s templates. The information pack includes all relevant aspects of the service and associated information such as patient rights, how to access the Health and Disability Commissioner and the nationwide advocacy service. A needs assessment is required prior to entry to ensure the service can provide the assessed level of care. The facility limits admission to rest home level residents who have good levels of mobility. The registered nurse stated there is good liaison with the needs assessors, mental health team, and general practitioners (GP). Two of five admission agreements sighted had been signed within the required timeframe. Exclusions (ie, additional services) from the service are included in the admission agreement.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There are guidelines for death, discharge, transfer and follow-up. When transferring, all relevant information is documented and transferred with the resident. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification for resident transfers.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The RN and caregivers administer medicines to residents. Caregivers administer the majority of medicines. All staff administering medications have completed an annual medication competency, which assesses caregiver knowledge but does not assess skills competency. Caregivers attend annual medication education to refresh their knowledge. Monthly medications received are reconciled by the RN, on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. The facility has a contract with a local pharmacist for the supply of medicines. Reconciliation of medications occurs on admission and when residents return from hospital. Nine of 10 medication charts sampled included photo identification and allergy status, with the exception of one resident who had been admitted for respite care. Medication charts sampled met the legislative prescribing requirements for all medicines except for ‘as required’ medicines and medicines that were being self-administered by residents. All medication charts sampled showed evidence of being reviewed by the GP three-monthly. Standing orders were not in use. The medicines administration round at lunchtime was witnessed and conducted correctly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All food is prepared and cooked on-site by the caregivers who are assigned to cooking duties on the roster. Baking and some food preparation is done by the night staff. There is a four weekly menu in use that has been reviewed by a dietitian as meeting the nutritional guidelines published by the Ministry of Health, as at 20 March 2015. Corrective actions have been implemented. The main meal is at midday. The resident likes and dislikes are documented and known to the caregivers. Residents have a food preferences/likes and dislikes form completed on admission. Alternatives are offered. Special diets are accommodated. High calorie diets and supplements are offered for residents with weight loss, if needed. Lip plates and smaller serving plates are available to promote independence at meal times. Festive occasions are celebrated and residents choose the menu for their birthday. The kitchen is well equipped with gas hobs, electric oven, freezers, one fridge/freezer and dishwasher. All perishable goods are date labelled. Fridge/freezer temperature monitoring and hot food temperature monitoring is occurring. Chemicals are stored in a lockable cupboard. Food is procured from local commercial suppliers and the supermarket. An external contractor or curbside recycling manages waste. Residents and family spoke positively about the meals and home baking. Resident meetings provide an opportunity for resident feedback on the meals. Caregivers attend food safety training (last provided in July 2015).  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service would record the reason (no bed availability or unable to meet the assessed level of care) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry were declined.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Initial assessments are completed on admission and are reviewed as part of the InterRAI assessment process. InterRAI assessments have been completed for the permanent residents. Other risk assessments have been completed as applicable. The outcomes of the risk assessment tools were reflected in the long-term care plans reviewed.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The service uses a care plan template that was individualised in the care plans reviewed to meet the resident’s needs in all areas. InterRAI assessments and risk assessments form the basis of the long-term care plan. The care plans reviewed described the resident needs and care interventions required to support the resident’s independence and wellbeing. Care plans are available to guide caregivers. Caregivers interviewed were knowledgeable regarding individual resident cares. There were short-term care plans in use for short-term needs and changes in health status. There is documented evidence of resident/family input into care planning and six monthly reviews.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s health status changes the registered nurse reviews the resident and if required refers to the GP or nurse specialist for a consultation. Family members are notified promptly of any resident health changes. Residents state their needs are being met. There are adequate dressing supplies available as required. No residents had wounds or pressure injuries on the day of audit. The RN has access to specialist wound management advice if necessary. Continence products are available. Resident continence needs are documented in the care plan. Monitoring forms were in use for pain management, weight management and other observations.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities officer is a retired NZ registered nurse who worked as the RN at the facility previous to her retirement. She is employed 9 hours a week over three days per week, to plan and implement the activity programme. She attends regional diversional (DT) meetings and receives minutes. Caregivers also assist with activities on days the DT is not there. Each newly admitted resident has an individual activities assessment and a social assessment completed and an individual activities plan is developed. The individual activities plan is reviewed six monthly when the resident’s care is reviewed. The activities officer develops a group activities plan. This is a weekly plan developed and displayed in the main lounge, which may change as necessary. Residents have the opportunity to provide feedback and suggestions for future activities, outings and entertainment. The programme is flexible and accommodates community visitors and groups. Residents are supported to attend their own church and are transported by families. A wheelchair taxi is hired at least weekly or more for outings. Special events and festive occasions are celebrated. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans reviewed had been evaluated six monthly. The six monthly review is completed with input from the multi-disciplinary team (RN, manager, caregivers, activity coordinator, GP, resident and relative). Short-term care plans sighted for short-term needs, had been reviewed and resolved. Written evaluation forms are used to document progress towards meeting the residents’ goals.  |
| 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 | Referral to other health and disability services occurs as needed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents’ files. The service has access to GPs, ambulance/emergency services, allied health professionals (eg, dietitian, podiatrist, and pharmacist) and mental health services for the older person. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is a waste and hazardous substance safety policy. Management of waste and hazardous substances are covered during orientation of new staff and as scheduled on the education planner. All chemicals sighted were labelled correctly and were stored in locked areas. Safety data sheets are available. Gloves, aprons, goggles and shoe covers are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building holds a current warrant of fitness, which expires 17 January 2016. Two of the double bedrooms are currently each occupied by one resident only. The building has internal and external ramps on the ground floor. There is a planned and a reactive maintenance programme in place. There is a communication book used for the daily maintenance requests. The manager coordinates and authorizes the contractors to carryout maintenance requests. Corrective actions are documented in the communication book. The manager is available on call for urgent matters. Electrical equipment not hard wired has been tested and tagged in May 2015. Not all of the medical equipment has been calibrated. Hot water temperature monitoring is completed monthly with readings within acceptable ranges. There is storage for equipment and supplies although space is limited. The interior of the home is well maintained and homely. There is an open plan combined dining area/lounge area and a second lounge area available. Residents were observed to be moving freely around the facility with the use of mobility aids. There is outdoor seating and shading in place. The grounds are well maintained. There is a safety gate across the driveway with plenty of street parking. The prospective provider has had a building report and an earthquake assessment completed and reports that no major issues were identified and as such, there are no plans to make any environmental changes to the facility in the next 12 months. |
| 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 | No resident bedrooms have hand basins or ensuite bathrooms. There are four resident communal toilets and a separate toilet for staff and visitors. There are three showers for residents. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. There are privacy locks on the doors on the showers and toilets. Residents interviewed confirmed staff provide the resident with privacy when attending to personal hygiene cares. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | The rooms are spacious enough for the residents to easily manoeuvre around with mobility aids as required. Residents are encouraged to personalise their rooms as desired. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is easy access to the communal areas. The dining area and main lounge area is open plan where activities take place. There is a second large lounge at the front of the building where residents can have visitors or spend time with quiet activities. Communal areas are accessible. There is adequate space to allow for individual and group activities to occur within the lounge.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are two dedicated cleaner/laundry persons employed for three hours a day who work a four on four off roster. They cover each other if the other cleaner/laundry person is absent. The caregivers do the majority of laundry with some assistance from the staff who concentrate on doing the cleaning. Laundry procedures and cleaning duties are documented. There is a commercial washer and a commercial drier and sink in the laundry. Dirty laundry is able to be pre-soaked. Linen is dried outside on the clothesline where possible. The laundry door is latched to prevent resident entry when staff are not in attendance. Caregivers are involved in doing laundry on all shifts. Chemicals are stored safely in the manufacturer’s containers in the laundry and in other locked areas. Safety data sheets are readily accessible. Protective clothing is available for staff. Chemical training occurs. The effectiveness of the cleaning and laundry service is monitored by the manager through resident and relative feedback, the internal audit programme and resident meetings. Residents and relatives are satisfied with the cleaning and laundry services.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. A fire evacuation was last held May 2015, which was attended by three staff. There is an approved evacuation plan, which was approved on 7 April 2000 that was completed following the last set of building alterations. There have been no more alterations since then. There is an emergency and business continuity plan and a pandemic plan and other health and safety policies in place to ensure health, civil defence and other emergencies are included. The facility is well prepared for civil emergencies and carries emergency equipment and supplies in the event of an emergency including PPE. Alternative energy sources are available as the kitchen has electricity and gas. The facility carries emergency lighting, battery backup and spare gas bottles/camp burners. A store of emergency drinkable water is available. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The call bell system is available in all areas and there are indicator panels above each door and in the middle of the facility. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The facility is secured at night. Residents interviewed stated their call bells were answered in a timely manner. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas are well ventilated. Bedrooms have an external window to allow natural lighting and ventilation. Fans and external doors are used in summer to remove heat from the building. There are oil-filled heaters in the bedrooms and panel heaters in the corridors and communal areas, which are used continually during the winter months. The residents confirmed the temperature of the facility is comfortable.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The infection prevention and control (IPC) programme is appropriate for the size and complexity of the service. The registered nurse is the infection prevention and control officer who is responsible for infection prevention and control. The facility has a suite of infection prevention and control policies. The infection prevention and control practices are authorised and reviewed annually by the registered nurse (last reviewed October 2015). The infection prevention and control programme results are discussed at the general staff meetings. There are notices on the entrances regarding cross infection by visitors to the site. |
| 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 | The infection prevention and control coordinator is supported by a team, which includes the manager, the owner and the head caregiver. She has access to GP advice, the laboratory staff, the infection prevention and control staff at the DHB and public health staff at the DHB.  |
| 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 | There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. Policies were last reviewed in October 2015. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The RN last completed refresher training in infection prevention and control in May 2015. The orientation package includes specific training around hand washing and standard precautions and training was provided both at orientation and as part of the annual training schedule (last provided in October 2015). A record has been kept of staff attendance.  |
| 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 | The surveillance policy is implemented as part of the infection prevention and control programme. Individual infections are recorded in a register and documented in clinical records. Monthly data is collated and reported to the general staff meetings. The type of surveillance undertaken is appropriate to the size and complexity of the service. The infection rate is low. Staff reported that there has been one outbreak of suspected gastroenteritis in late September, which involved four residents and at least three staff. Residents were isolated when symptoms were noticed and staff observed standard precautions. Outbreak records were not kept or any samples collected and sent to the laboratory and the outbreak was not notified to any external agency (link finding 1.2.4.2). Collation of September surveillance records in October have yet to occur. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service has a restraint free philosophy. On the day of the audit there were no reported events of either restraint or enabler use by residents. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. Staff received training around restraint minimisation in February 2015.  |

# 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 1.2.4.2The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | The manager is aware of the statutory and regulatory obligations to report essential information to external agencies. The RN and caregivers interviewed reported that there was a recent outbreak of suspected gastroenteritis in late September 2015, which involved a number of residents and staff over a number of days. The RN implemented isolation precautions; however, the outbreak was not recognised as a reportable event and therefore not reported to public health.  | There was an outbreak of suspected gastroenteritis in September 2015 involving a number of residents and staff, which was not reported to public health. | Ensure public health is notified immediately of any suspected outbreaks of infections.60 days |
| Criterion 1.2.9.1Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | Current clinical records are stored on site in non-resident areas. A number of clinical records for existing residents were archived off site and were unable to be accessed on the day of audit (link 1.3.1.4). Dates of events in clinical records are not being recorded in full. | Dates of events in clinical records are not being recorded in full and this practice was noted to be systemic. Staff were recording events as either day and month but not the year, or month and year but not the date.  | Ensure staff record dates fully in clinical records and ensure clinical records for current residents are able to be accessed. 90 days |
| Criterion 1.3.1.4Entry 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. | PA Low | Five residents and two relatives interviewed confirmed they received adequate information about the services on or prior to entry to the facility. Two of five admission agreements reviewed had been signed within the required timeframe as specified in the aged residential care agreement.  | Two of five residents in the sample of records reviewed had not signed their admission agreement within the required timeframe, as specified by the aged residential care agreement and the admission agreement and admission documentation was not able to be sighted for the third resident who was admitted in 2011 as it was stored offsite. | Ensure all residents, or their nominated representative, signs an admission agreement, either on the day that the resident commences receiving services, or, in the case of an emergency admission, as soon as is reasonably practicable but no later than 10 working days after the resident is admitted. 60 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | There are medication management policies/procedures in place. The RN and caregivers administer medicines to residents. The service uses four weekly blister packs. Shortfalls were identified around medication management.  | (i) One of 10 records for a resident having respite care did not contain photo identification, allergy status, or correct charting of all medicines being administered. (ii) Insulin is being stored in the kitchen refrigerator, which is not secure as it is able to be accessed by residents and visitors anytime. The temperature of the kitchen refrigerator is not monitored weekly to ensure that the Insulin or other refrigerated medicines are stored at the correct temperature. | (i) Ensure that each resident’s medicine management records contain photo identification and allergy status. (ii) Ensure that medicines requiring refrigeration are stored in a medicines-dedicated refrigerator, are stored securely when not in use, that the temperature of the refrigerator is monitored weekly to ensure the correct temperature range and that records kept of the monitoring procedure.60 days |
| Criterion 1.3.12.3Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | The registered nurse manages medicine management with the majority of medicines administered by caregivers. There is a system in place, whereby the registered nurse assesses the competency of caregivers to administer medicines. The competency system documents the assessment of the caregiver’s knowledge only and does not include any documentation that the caregiver has been demonstrated competent skills in the administration of medicines. Caregivers are administering insulin to one resident. | (i) The skills competency of caregivers in the administration of medicines is not being witnessed and assessed by the registered nurse. (ii) There is no policy in place for insulin management. (iii) There is no separate competency system in place for caregivers who are managing insulin administration. | (i) Ensure the system of medicines administration competency in use includes an assessment of both skills and knowledge. (ii) Ensure Insulin administration is managed according to policy. (iii) Ensure a specific competence procedure is implemented for staff involved in insulin administration.60 days |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There were two residents’ self-administering medicines on the day of audit. Both residents had signed an agreement to self-administer medicines; however, other documentation was incomplete. There was no secure storage in place. | (i) One resident was self-administering a medicine that was not documented on the resident’s medicine order signed by the general practitioner. A pharmacist had issued the medicine. (ii) There was no evidence of regular competency assessments having been completed by the registered nurse or prescriber for the two residents self-administering medicines. (iii) There was no evidence on the medicines charts for the two residents as to what medicines were being given by staff and what medicines were being given by the resident. (iv) There was no evidence in the administration records that caregivers had checked with the resident that they had taken all medicines on each shift. (v) Residents did not have access to secure storage in their rooms. | Ensure that residents who are self-administering medicines are managed according to the requirements specified in the medicines care guides for residential aged care.60 days |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | General practitioners are prescribing ‘as required’ medicines for residents, however only the prescribing in two of ten medication records reviewed were correctly charted according to the medicines care guidelines for residential aged care.  | Eight of ten medicine records reviewed evidenced incomplete documentation to guide caregivers when administering as needed medicines. | Ensure all ‘as required’ medicines are recorded correctly when prescribed by general practitioners.30 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The facility manager or the RN commences the assessment process on admission. The RN reviews the interim plan of care and develops the long-term care plan within three weeks of admission. The RN completes the InterRAI documentation. A general practitioner had seen four of five residents within two working days of admission. | A general practitioner had not seen one of five residents within two working days of admission for a planned admission from the community.  | Ensure primary medical treatments occur as specified in the Aged Residential Care agreement.60 days |
| Criterion 1.4.2.1All buildings, plant, and equipment comply with legislation. | PA Low | The building and plant complied with legislation and the prospective purchaser has completed a building report and assessment for earthquake preparedness. There is a supply of general mobility aids on site including commodes and shower stools. Residents have access to walking frames. Staff were using a set of stand-on weighing scales that were purchased in March 2015. The facility has one hoist, which had its annual service on 26 May 2015. Not all medical equipment has been calibrated. | The service was using two sphygmomanometers, one of which was not suitable for use as a medical measuring device, as stated by the manufacturer, and the second sphygmomanometer had never been calibrated according to management. | Ensure all medical measuring equipment is calibrated in order to ensure confidence in their functioning and measurements. 60 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.