# G A & H J Lydford

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by HealthShare 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:** G A & H J Lydford

**Premises audited:** Tarahill Resthome

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

**Dates of audit:** Start date: 5 October 2015 End date: 5 October 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:** 11

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Tarahill Rest Home can provide care for up to nineteen residents.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is responsible for the overall management of the facility and is supported by a registered nurse.

Improvements are required to the following: care planning, medication processes and human resources processes.

## Consumer rights

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

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system.

## Organisational management

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

The organisation's mission statement and vision is documented. There is a current business and quality plan. Quality and risk management systems support service delivery and include internal audits, complaints management, resident and relative satisfaction surveys, and incident/accident management. Quality and risk management activities and results are shared among staff, residents and family with the facility manager driving quality improvement.

Human resource policies include some recruitment information, selection, orientation, staff training and development. An improvement is required to documentation of referee checks, criminal vetting and monitoring of annual practicing certificates for health professionals. Staffing levels meet occupancy and acuity levels and residents state that they have adequate access to staff when needed.

Resident records are maintained in a secure manner.

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

Each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family confirmed their input into care planning.

Admission agreements and needs assessments are documented with an interRAI and specialised assessments completed within required periods. Care plans include interventions as per individual needs and are reviewed six monthly. Care plans should be updated as changes occur.

Residents and family confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

A secure medicine dispensing system is in place. Staff responsible for medicine management have current medication competencies apart from the registered nurse and facility manager. Staff administered medications as per policy during the audit. Registered nurse initiated orders are to stop being used with the service required to review the practice.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Any additional dietary requirements are being met. The kitchen staff have completed food safety training.

## 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. |

All building and plant comply with legislation with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed.

## 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. |

Restraint policies and procedures include definitions of restraint and enablers, which are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. The facility manager and staff state that restraint is not used in the home and there were no enablers used during the audit.

## Infection prevention and control

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

Infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Infection control is an agenda item at staff meetings with surveillance of infections occurring.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 42 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 1 | 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 Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. New residents and families are provided with copies of the Code as part of the admission process.  Staff have had training around rights and the Code. Staff were observed to implement rights as per the Code in their day-to-day practice. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service information pack includes information regarding informed consent. The facility manager, or the registered nurse, discusses informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes.  The informed consent policy and procedure directs staff in relation to gaining informed consent. This included guidelines for consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them, and that the resident and/or significant others are included in the planning of that care.  All resident files identify that the required consents are collected. This includes advance directives signed only by the competent resident. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service.  Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.  Discussions with family and residents identifies that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident’s family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There are no set visiting hours and family report that they are encouraged to visit at any time. Residents confirm that they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service also encourages the community to be a part of the residents’ lives with visits from entertainers. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. Complaints management is explained as part of the admission process and is part of the staff orientation programme and ongoing education. Residents and family confirm that the management open door policy makes it easy to discuss concerns at any time.  The complaints register records the complaint, dates and actions taken. There were no outstanding complaints at the time of the audit and there have been no complaints to external authorities since the last audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The facility manager or registered nurse discusses the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code are also held at the resident meetings.  Information regarding the Health and Disability Advocacy Service is clearly displayed in the facility. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.  Residents and family confirm that their rights are being upheld by the service. They are able to describe their rights and advocacy services particularly in relation to the complaints process. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity and respect and quality of life. Residents’ support needs are assessed using a holistic approach. The assessment process includes gaining details regarding people’s beliefs and values. Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name. Caregivers state that they support the residents' independence by encouraging them to be as active as possible  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. This includes strategies to manage any behaviours of concern.  The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility which can be used for private meetings. Caregivers reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirm that their privacy is respected. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service implements the Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan. Links to local Maori are available through the church who visit weekly.  Any Maori resident living at the facility has their cultural needs assessed with any preferences documented. Residents confirm that their cultural needs are well met. Staff are aware of the importance of family in the delivery of care for the Maori resident. All staff have received training on cultural safety. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies each resident’s personal needs from the time of admission. This is completed with the resident, family and/or their representative having input into the admission, assessment and planning processes.  Residents determine when cares occur, times for meals, choices in meals and choices in activities. Caregivers described how they encourage residents to be as independent as possible. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff files have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. Families and residents expressed no concerns with breaches in professional boundaries, discrimination or harassment. Staff orientation and their employee agreement includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. These align with the health and disability services standards. Policies are reviewed at least two yearly.  A staff training programme is implemented and staff described sound practice based on policies and procedures, care plans and information given to them via the registered nurse.  Consultation is also available with health professionals and specialists in the region with staff able to describe how and when they can make contact. Residents and families interviewed expressed a high level of satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure was available. Family members interviewed confirm that they are informed if the resident has an incident, accident, or has a change in health or needs. Family contact is recorded in residents’ files.  Interpreting services are available from the district health board. There were no residents requiring interpreting services at the time of the audit.  The information pack is available in large print and this could be read to residents. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There are two owners who live next door to the facility. One is the facility manager and has been in the position for 20 years (enrolled and psychiatric nurse). The other owner takes on the role of maintenance for the facility and the owners have owned the facility for over seven years. Both are on site during the weekdays and weekends and are supported by the registered nurse who provides six hours a week support and the diversional therapist who is identified as the second in charge. The facility manager has at least eight hours training relevant to the role, annually and has trained in interRAI.  There is a philosophy documented with this displayed in the foyer.  The facility can provide care for up to 19 residents requiring rest home level of care. There are currently 16 residents in the service. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The diversional therapist is designated as second in charge with the diversional therapist having a sound understanding of the role. The role is documented. The registered nurse provides clinical support and advice when the facility manager is on leave. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Tarahill has a quality and risk management framework that is documented to guide practice. There are business and quality plans with annual reviews documented. The facility manager completes annual reviews of each aspect of service delivery using a monthly audit schedule to ensure that all audits and reviews are completed thoroughly. Annual reviews include the following: health and safety; safe medications; restraint; service delivery; challenging behaviour; infection control.  Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues documented when these are identified.  There are monthly staff meetings held that include all aspects of the quality programme. There are monthly resident meetings with family able to attend if they choose to.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies having been reviewed last in 2014 and 2015 with the registered nurse and facility manager involved in the review. Policies are readily available to staff in hard copy in the office. Staff interviewed state that they read any new or revised policies.  All staff interviewed including the caregivers, the diversional therapist and the cook report they are kept informed of quality improvements.  The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures are in place for the service. There is a health and safety audit completed six monthly. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.  There is an annual resident/family satisfaction survey and results documented from the 2014 and 2015 surveys indicate that residents and family are very happy with the service and environment with minimal suggestions for improvement. Residents receive a copy of the survey report. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The facility manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. The appropriate authorities were notified in 2015 following an outbreak of infection.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the facility manager and diversional therapist.  Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.  Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at the monthly staff meeting. Analysis of incidents and accidents occurs monthly with trends analysed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | The registered nurse and the facility manager hold current annual practising certificates. The service should monitor the annual practicing certificates of visiting health practitioner’s for example the general practitioner, dietitian and podiatrist.  Staff files included a signed contract, privacy and confidentiality forms and evidence of orientation including a 'buddy' checklist. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid certificates are held in staff files along with other training records. Records of referee checks and criminal vetting should be completed with documentation retained in staff files.  All staff undergo a comprehensive orientation programme that meets the educational requirements of the Aged Residential Care (ARC) contract. Caregivers are paired with a senior caregiver for shifts until they demonstrate competency.  Annual medication competencies are completed for all caregivers (refer 1.3.12).  There is a training plan implemented and staff state that they find the training relevant to their needs with at least eight hours completed per year. |
| 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 around staffing which is the foundation for work force planning. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.  The facility manager is on call. A registered nurse is on site six hours a week and is available on call every second weekend. Staff confirmed that the facility manager or registered nurse is available at any time and they respond immediately if rung.  There are 18 staff including the facility manager, diversional therapist, cooks and caregivers. The other owner is responsible for maintenance.  Residents and families confirm staffing is more than adequate to meet the residents’ needs and residents and family members praised the staff and facility manager as providing a resident focused service. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Information is entered into the resident information management system in an accurate and timely manner. Information of a private or personal nature is maintained in a secure manner and is not publicly accessible. Archived records are stored onsite.  Progress note entries are made by staff on duty on each shift. Records are legible and the name and designation of the staff member documented.  Each resident has a file that includes assessment, planning and other information related to their care. Resident information related to care is integrated. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry and assessment processes are recorded. Information is communicated to residents, family, relevant agencies and staff. The admission agreement defines the scope of the service and includes all contractual requirements.  Residents and family confirmed the admission process is completed in timely manner with family engaged in the admission process when at all possible.  Each resident has a needs assessment completed prior to admission to the facility and held in the resident file. Admission agreements are completed on admission. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is appropriate communication between families and other providers that demonstrates that transition, exit, discharge or transfer plans are communicated, when required. The residents’ files evidence appropriate records relating to transfers where this is required. |
| 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 | A detailed medication policy documented is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. Caregivers who administer medications have completed medication competencies for 2015. The facility manager and registered nurse are required to complete competencies. The caregiver observed administering the lunchtime medication complies with regulation requirements. An apron was worn to identify the caregiver completing the round so as not to be disturbed at this time.  The controlled drugs are checked weekly by two staff, one of whom is a registered nurse. Six monthly reviews by the contracted pharmacist occurs. There were closed containers in use for medication in the fridge to separate this from food. Fridge temperatures were within the normal range required for safety purposes. Storage is appropriate.  One resident is self-administrating some medication with a competency completed by the facility manager confirming that the resident is able to self administer medication as per the prescription.  Medication records reviewed evidence photo identification on each resident record sheet. Any allergies or sensitivities are documented on the medical notes and the resident`s medication record. All medications are prescribed individually and signed and dated by the GP. There is no evidence of any transcribing of instructions. The registered nurse or facility manager checks the medication packs when received from the pharmacy.  On the day of the audit, there were registered nurse initiated orders in place. An improvement is required to registered nurse initiated medication orders. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The rest home uses the summer/winter seasonal menu which has been reviewed by a dietitian in 2015. Nutritional guidelines for older people are available and considered when the menu plans are developed.  The evening meal is served as the main meal and residents stated that they preferred this option.  An individual dietary assessment (nutritional status) is completed on admission for all residents which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over twenty-four hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the resident`s GP and notifying the kitchen of extra dietary requirements. The service is managed by two cooks over seven days. Special diets can be arranged, for example puree, fortified fluids, vegetarian diets or gluten free diets.  Evidence is sighted of meal planning, cleaning routines and audit requirements being completed. All staff have completed relevant food safety certificates, infection control and first aid certificates and each staff member has their own record maintained by the facility manager. The cook reports that both cooks are supported by management with the ordering and purchasing of food supplies and they are able to describe individual requirements of the residents. Foods are stored above floor level and the fridges and freezers are monitored on a daily basis. |
| 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 | There is a process to inform residents and family, in an appropriate manner, of the reasons why the service has been declined. The residents would be declined entry if not within the scope of the service or if a bed was not available. The facility manager communicates with the needs assessment service when any issues arise. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility has processes in place to seek information from a range of sources, for example; family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.  There was evidence of residents' discharge/transfer information from the district health board (DHB), where required. The facility has appropriate resources and equipment as confirmed through staff interviews and observation of the environment.  Assessments are conducted in a private setting with residents seen in the rooms. Residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.  InterRAI assessments are documented and used as the basis of planning with an initial assessment completed on the day of entry. Risk reassessments are consistently completed when required (refer 1.3.8). The service is continuing to use specialised assessment tools including the mini nutritional assessment, Braden scale for identifying risk of pressure areas, safe handling assessment and a falls assessment. These are completed at least annually or when there are changes noted for the resident. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Residents’ care plans are individualised. Care plan interventions reflect the level of care required.  Staff report they receive adequate information for continuity of residents’ care. The residents have input into their care planning and review.  Resident files reviewed included detailed plans around specific issues when these were identified for example around management of challenging behaviours and wound management. There is evidence of specialist involvement where this is required. Any recommendations made by visiting health professionals such as the wound care specialist or mental health service staff are included in the individual resident’s plan. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans evidence interventions, desired outcomes or goals of the residents. The GP progress notes include reviews that have occurred three monthly or as these have been required. Residents and family confirm that resident’s current care and treatment meets their needs. Family communication is recorded in the residents’ files.  The registered nurse documents any review of residents with the staff confirming that they are familiar with the current interventions of the resident. Short term care plans are developed, when required and signed off by the registered nurse or facility manager. They record the detail of information required. The registered nurse or facility manager signs these off as completed when the issue is resolved. Progress against the short term plan is recorded in the progress notes. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist (DT) has an allocation of 30 hours in the service per week. The programme is planned with the residents having input through the resident meetings and on a one to one basis. The activities programme is displayed on a weekly/monthly calendar with individual assessments and plans documented by the diversional therapist. The diversional therapist completes monthly documentation of participation and there is a daily attendance register kept for each resident. Caregivers also support activities according to the activities programme when the DT is not present. Assessments and plans with evidence of review was sighted in all resident files reviewed.  Regular exercises are provided and the programme includes intellectual activities, spiritual activities, input from external agencies and supported ordinary unplanned/spontaneous activities including celebrations and celebrations. The programme reviewed is implemented ensuring the strengths, skills and interests of residents are maintained.  Residents report they are happy with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Periods in relation to care planning evaluations are documented. Residents and family confirm their participation in care plan evaluations.  The residents’ progress records are entered in daily. When resident’s progress is different from expected, the RN contacts the GP, as required. Family were notified of any changes in resident's condition with this confirmed at family interviews.  There was recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this was required.  The care plan is updated as changes in residents needs occur on most occasions with an improvement required to ensure that plans are updated consistently when changes are identified. |
| 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 | Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirms family involvement. Residents’ progress notes confirm that relevant processes are implemented with appropriate referrals made. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis.  Chemicals are stored securely and the required personal protective equipment/clothing (PPE) is available. Staff confirm they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required.  The caregivers demonstrated knowledge of handling waste and chemicals and were observed to keep the cleaning trolleys in sight when in use. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 17 June 2016). There have been no building modifications since the last audit.  There is a planned maintenance schedule implemented with the owners completing maintenance as required.  The areas are suitable for residents with mobility aids.  Electrical safety testing occurs annually and all electrical equipment sighted has an approved testing tag. Clinical equipment is tested and calibrated by an approved provider annually.  The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered.  There are external areas with a veranda, outdoor areas with shade and access to garden areas. Residents and family members confirm that the environment is suitable to meet their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible communal toilets/bathing facilities. There is a visitor’s/staff toilet. Communal toilet facilities have a system that indicates if it is engaged or vacant.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members interviewed report that there are sufficient toilets and showers. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Rooms can be personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own. Residents spoke positively about their rooms.  There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a lounge/dining area that is also used for activities. Residents can choose to have their meals in their room. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The service has procedures in place for cleaning with staff able to describe how they complete cleaning tasks. There is a dedicated locked storage area for cleaning equipment and chemicals. Staff state that there is training on the use of products and staff are reminded to keep the trolley with them at all times. Cleaning is monitored by the facility manager. The facility was clean on the days of audit.  All laundry, including residents’ personal laundry is completed on site with a dirty and clean flow in place.  Staff and residents interviewed confirm they always have enough linen to meet day-to-day needs. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation scheme.  Emergency management policies and procedures guide staff actions in the event of an emergency. Emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked monthly by an approved provider.  Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking. Extra cooking facilities are available at the owner’s house that is attached to the rest home.  The emergency evacuation plan and principles of evacuation are documented in the fire service approved fire evacuation plan. All resident areas have smoke alarms and a sprinkler system. Emergency education and training for staff includes six monthly trial evacuations and there is always a staff member on duty with a current first aid qualification.  Appropriate security systems are in place with staff checking that the premises are secure at night. Staff and residents confirm they feel safe at all times. Call bells are located in all resident areas. Resident and family/whānau confirm call bells are answered within an acceptable timeframe. Call bells randomly checked on the day of the audit are displayed and 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 | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.  Family and residents state that the building is maintained at an appropriate temperature in both winter and summer. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Infection control (IC) policies and procedures provide information and resources to inform staff on infection prevention and control. The delegation of oversight of the infection control programme is documented in policies and procedures. The infection control coordinator (ICC) is the facility manager in partnership with the registered nurse.  There is evidence that the staff meetings include discussion of the infection control programme and in particular of any resident issues and surveillance. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including the infection control manual; internet; access to experts and education that the facility manager completes annually.  The staff meeting includes discussion of infection control.  The interview with the facility manager /ICC confirms awareness of their responsibilities of the position. The visual inspection evidences that there are resources such as paper towels and flowing soap provided. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user-friendly format and contain an appropriate level of information. Policies are readily accessible to all personnel as confirmed at staff interviews. The IC policies and procedures are developed and reviewed at least two yearly. IC policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. Staff state that clinical staff identify situations where IC education is required for a resident such as hand hygiene; cough etiquette and one on one education is conducted.  Education sessions are documented with a record of staff attendance maintained. The facility manager/ ICC has completed IC education relevant to their position on an annual basis. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections is recorded and there is evidence the data being analysed and evaluated.  Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events with these retained in individual resident files. Staff report they are made aware of any infections of individual residents by way of feedback from the facility manager or registered nurse, through verbal and written handovers and through documentation in progress notes.  An outbreak occurred in May 2015. The service accessed advice and support from the public health service and infection control specialist with an action plan documented. The Waikato District health Board policy was followed around management of scabies and outcomes of the outbreak documented. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures on restraint minimisation and use of enablers are documented and there are links with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use.  There is no evidence of restraint or enablers being in use at this facility.  The service has a commitment to a ‘non-restraint’ policy, philosophy and appropriate use of enablers/restraint. Enablers are only used for safety reasons. Staff interviewed understood that the use of enablers is to be a voluntary and the least restrictive means to meet the needs of residents with the intention and/or maintaining of a resident’s independence. Training records evidence training occurs at orientation and is ongoing. The facility manager is the restraint co-ordinator. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.2  Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | The registered nurse and the facility manager have a copy of their annual practicing certificate on file.  The facility manager recruits new staff. Most new staff are known to the facility manager who has not felt that there has been a need to vet staff by using a criminal vetting process or to document referee checks. The facility manager describes verbally checking references. | The service does not monitor the annual practicing certificates of visiting health professionals. Criminal vetting does not occur and referee checks are not documented. | Monitor the annual practicing certificates of visiting health professionals. Complete checks of new staff with documentation of criminal vetting and reference checks.  180 days |
| Criterion 1.3.12.1  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. | PA Moderate | The service has documented registered nurse prescribed and initiated orders written by the registered nurse. The issue of registered nurse initiated orders was discussed with the registered nurse and facility manager on the day of the audit and the service advised that these should stop being used. The facility manager and registered nurse agreed that these would no longer be used after the audit. The facility manager is in the process of considering the use of standing orders. | Registered nurse initiated orders with nurse prescribing are used in the service. | Stop using the registered nurse initiated orders on the day of the audit and implement standing orders if still required. The timeframe designated for this corrective action is 90 days for the review process to occur and standing orders to be put in place if still required noting that the service has confirmed that they would cease using the registered nurse initiated orders on the day of audit.  90 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Any staff administering medications are required to complete an annual medication competency. Staff files confirm that caregivers who administer medications have had a medication competency completed. | The registered nurse and facility manager administer medications but have not completed annual medication competencies. | Ensure that the registered nurse and facility manager complete annual medication competencies.  90 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Each care plan is reviewed six monthly. There are instances noted in resident files when the care plan is updated as changes occur. | There are instances noted in two files reviewed where changes in the resident’s condition had occurred outside of the six monthly review period and the care plans had not been updated to reflect the management of the issues. | Ensure that care plans are updated as changes to care are identified.  90 days |

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

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

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

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

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

End of the report.