# Kapsan Enterprises Limited - Chadderton Rest Home

## 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:** Kapsan Enterprises Limited

**Premises audited:** Chadderton Rest Home

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

**Dates of audit:** Start date: 9 November 2015 End date: 9 November 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:** 19

# 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. Chadderton Rest Home can provide care for up to twenty-three residents.

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

The managing director and clinical manager are responsible for the overall and clinical management of the facility.

An improvement is required to criminal vetting of staff and to ensure that there is sufficient water on site in the event of an emergency.

## 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.

Human resource policies include recruitment information, selection, orientation, staff training and development. An improvement is required to criminal vetting. Staffing levels meet occupancy and acuity levels and residents state that they have adequate access to staff when needed.

Resident records are integrated and 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. |  | Standards applicable to this service fully attained. |

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 and specialised assessments completed within required periods. Care plans include interventions as per individual needs and are reviewed six monthly. Care plans are 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.

Staff responsible for medicine management have current medication competencies. Staff administered medications as per policy during the audit with medicines kept in a locked trolley or cupboard.

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

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

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 although the amount of water on site in the event of an emergency should be reviewed. There are emergency drills completed at least six monthly. Call bells allow residents to access help when needed. An improvement is required to ensure that there is sufficient water on site in the event of an emergency.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint 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 clinical 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

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

Infection prevention and control 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 | 43 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | 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 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 | The service information pack includes information regarding informed consent. The clinical manager or the registered nurse discusses informed consent processes with residents and their families 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 or for one resident, signed by the doctor who states that resuscitation is not clinically indicated.  |
| Standard 1.1.11: Advocacy And SupportService 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 and chosen social networks. |
| 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 | A significant number of residents in the service do not have family. 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 or as part of the planned activities programme. Residents continue to be as independent as possible with activities in the community. Residents interviewed described walking, visiting the library, shopping as activities they continued to do by themselves. The service also encourages the community to be a part of the residents’ lives in the service 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 DeliveryConsumers are informed of their rights. | FA | The clinical 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 in the context of the service. Information regarding the Health and Disability Advocacy Service is 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 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 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 confirm 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.Some residents share rooms. All agree to this as confirmed in interview with residents. There are curtains around each bed to ensure that there are areas of privacy for each resident.  |
| 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 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 district health board and a local service provider who is known to the clinical manager. 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 in 2015. |
| 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 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, choices in meals and choices in activities. Caregivers described how they encourage residents to be as independent as possible. The assessment and care plan includes identification of any cultural needs.  |
| Standard 1.1.7: DiscriminationConsumers 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 state that there have been no breaches of professional boundaries, discrimination or harassment. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. |
| Standard 1.1.8: Good PracticeConsumers 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 as changes to legislation or practice occurs with these updated at regular intervals. 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 clinical manager, managing director or 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. The clinical manager works one day a week for a private hospital and attends their training days. Residents and families interviewed expressed a high level of satisfaction with the care delivered.  |
| Standard 1.1.9: CommunicationService 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. A family member interviewed confirmed 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 are no residents requiring interpreting services at the time of the audit. One resident who has English as a second language has staff who interpret and talk with them. They also have family who visit daily. 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: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There are two owners who live close to the facility. One is the managing director who provides operational management and the other is the clinical manager (registered nurse). The owners have owned the facility since 2004. Both are on site during the weekdays and weekends and are supported by the registered nurse who works two days a week. The clinical manager has at least eight hours training relevant to the role, annually and has trained in interRAI.There is a philosophy documented and residents and family are informed of the philosophy.The facility can provide care for up to 23 residents requiring rest home level of care. There are currently 19 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 managing director and the clinical manager (owners) state that there is always one of them available to manage the service even if one is away. |
| 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 | Chadderton Rest Home has a quality and risk management framework that is documented to guide practice. There are business and quality plans with annual reviews documented. The managing director and clinical manager have delegated most internal audits to be completed by the registered nurse who documents action plans when issues are identified and evidence of resolution of issues. Service delivery is monitored also through review of complaints, review of incidents and accidents with monthly analysis of data and surveillance of infections. There are monthly staff meetings held that include all aspects of the quality programme. There are quarterly 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 as changes in legislation and best and evidence based practice are identified. The policies are developed and reviewed by an external consultant. Policies are available to staff and 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. Hazards and management of any risks is an agenda item at each staff meeting.There is an annual resident/family satisfaction survey and results documented from the 2015 surveys indicate that resident or family who returned the survey are happy with the service provided.  |
| 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 managing director and the clinical manager are 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 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 and the clinical manager. 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 when the resident has family. 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 clinical manager hold current annual practising certificates. The service also holds copies of annual practicing certificates of visiting health practitioner’s for example the general practitioner, pharmacists and dietician. Staff files included a signed contract that includes privacy and confidentiality 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. An application form is completed in all files and records of referee checks are kept. The service does not complete criminal vetting.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. There is a training plan implemented and attendance records kept for each staff member. Training is provided by external providers including the district health board and staff state that they find the training relevant to their needs with at least eight hours completed per year. Staff also state that they value the training around management of challenging behaviour.  |
| 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 managing director and the clinical manager are on call. Staff confirmed that the clinical manager is available at any time and they respond immediately if rung. There are 14 staff including the managing director, clinical manager, diversional therapist, household staff and caregivers. A registered nurse is on site for two days a week. Residents and families confirm staffing is more than adequate to meet the residents’ needs and residents and the family member interviewed praised the service for the care provided.  |
| 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 with additional nursing notes added at least two times a week. 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. One resident who is under the age of 65 years has a needs assessment completed by the needs assessment service and all others are assessed by the needs assessment service.  |
| 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. | FA | A detailed medication policy documented is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. Caregivers, the registered nurse and the clinical manager who administer medications have completed medication competencies for 2015. The caregiver observed administering the lunchtime medication complies with regulation requirements. Medicines are kept in a locked trolley with some oral medication and creams stored in a locked cupboard. A new fridge to store medication has been purchased and is in use. Temperatures are checked regularly. There are no residents requiring the use of controlled drugs. The clinical manager was able to describe a process for management of controlled drugs that included these being checked weekly by two staff, one of whom is a registered nurse should they be used. As required medications are charted with documentation of indications for use and maximum dose per hour. One verbal order was sighted and this had been signed by the general practitioner at the earliest opportunity after recording. One resident is self-administrating some medication with a competency completed by the registered nurse confirming that the resident is able to self administer medication as per the prescription. The inhaler is kept by the resident in their bedroom drawer. There is a notebook for the resident to record when they have had it and the registered nurse checks weekly. 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 clinical manager checks the medication packs when received from the pharmacy. There are standing orders reviewed annually and signed by the general practitioner.All medications are current with expiry dates checked and any expired medication returned to the pharmacy when identified.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The rest home uses the summer/winter seasonal menu which has been reviewed by a dietitian in November 2014. Nutritional guidelines for older people are available and considered when the menu plans are developed. An individual dietary assessment (nutritional status) is completed on admission for all residents which identifies individual needs, allergies 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 managing director. 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 clinical manager communicates with the needs assessment service when any issues arise. The clinical manager at times visits the potential resident in their current abode e.g. mental health services prior to accepting the resident. The clinical manager would discuss any potential issues with the needs assessment service prior to the referral being made formally.  |
| 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 being documented for the first time with 10 of 19 completed to date. Both the registered nurse and the clinical manager have completed the training and the assessments are used as the basis of planning with an initial assessment completed on the day of entry. Risk reassessments are consistently completed when required as part of the challenging behaviour assessments with all files reviewed having these completed. The service uses specialised assessment tools including the Braden scale for identifying risk of pressure areas and a falls assessment. Other tools are used when required for example a pain scale is used to assess pain. 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 incontinence. There is evidence of specialist involvement where this is required. Any recommendations made by visiting health professionals such as the mental health service staff are included in the individual resident’s plan. Requests from the general practitioner are included in the care plan with the general practitioner stating that any directions are followed up well. Short term care plans are well used for short term needs such as infections, skin tears and challenging behaviours if these are out of the ordinary. |
| 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 according to timeframes documented. Residents and family confirm that resident’s current care and treatment meets their needs. There is a client relative/friend/healthcare professional communication record kept in the residents’ files. This documents the date, method of communication, details of the communication and any comments or follow up required. 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 clinical manager. They record the detail of information required. The registered nurse or clinical manager signs these off as completed when the issue is resolved. Progress against the short term plan is recorded in the progress notes. There is a daily care monitoring record completed by the caregiver on duty and retained in the resident’s file. The registered nurse or senior caregiver monitors to ensure all cares have been completed in a timely manner. Vital recordings are taken as per resident need and at least monthly. A review of the forms with attention to specific needs of the resident as identified through interview and through the care plan indicate that residents are monitored as per their individual requirements. One resident, for example, was required to gain weight having been underweight and malnourished on entry and records indicated that the weight was monitored weekly with the resident no long requiring supplements having gained appropriate weight in the six month period. Another was required to lose weight and the record of weekly weights indicated that they had achieved that goal.  |
| 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 diversional therapist (DT) has an allocation of 40 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 were 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 are encouraged to maintain activities in the community with some residents going to the library, some who walk and others who attend community activities. 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. | FA | 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. If the resident has family involved, they are 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. Short term care plans are also signed off when the episode of care required has been completed.  |
| 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. Communication sheets confirm family involvement and involvement of other health professionals. 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 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 two yearly 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 to the front and one to the rear, 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 FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate 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 DiningConsumers 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 ServicesConsumers 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 clinical 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. | PA Low | There is an approved evacuation scheme confirmed in a letter from the New Zealand Fire Service in 2015. 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 some water on site. 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. 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. There are security cameras installed in communal areas and on the grounds for resident safety. Staff and residents confirm they feel safe at all times. Call bells are located in all resident areas. Resident and family confirm call bells are answered within an acceptable timeframe. All residents are mobile and staff state that they seldom ring call bells. 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 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 | 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 clinical manager. 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 programmeThere 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 clinical manager completes at least annually. The staff meeting includes discussion of infection control. The interview with the clinical 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 proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The 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 as changes occur by an external provider. 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 clinical manager/ ICC has completed IC education relevant to their position on an annual basis.  |
| 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 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 clinical manager or registered nurse, through verbal and written handovers and through documentation in progress notes.  |
| Standard 2.1.1: Restraint minimisationServices 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 clinical manager is the restraint co-ordinator. There is a gate at the front entrance that can only be opened through a key pad. The number of the key pad is on the gate and residents interviewed confirmed that they can freely go out of the gate.  |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Staff complete an application form with referee checks completed prior to appointment. |  Criminal vetting is not completed.  |  Complete criminal vetting prior to appointing staff. 180 days |
| Criterion 1.4.7.4Alternative energy and utility sources are available in the event of the main supplies failing. | PA Low | There are 70 litres of water on site as stored water. The service uses a gas heated continuous flow system.  | There is insufficient water on site for three litres of water per day for three days per resident.  | Ensure that there is sufficient water on site in the event of an emergency. 90 days |

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

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

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

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

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End of the report.