# Presbyterian Support Central - Reevedon Resthome

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

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

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

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Reevedon Resthome

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

**Dates of audit:** Start date: 16 November 2015 End date: 17 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:** 30

# 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

Reevedon Home is part of Presbyterian Support Central and provides rest home level care for up to 42 residents. On the day of audit, there were 30 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, management, staff and a general practitioner. No family were available during the audit.

The manager has been in her role at Reevedon Home for 18 months and has been a manager with Presbyterian Support Central for five years. A clinical nurse manager/registered nurse supports her.

There are three areas of continuous improvement awarded around implementation of the Eden philosophy; the quality and risk management programme; and the activities programme. Improvements are required around the induction programme, clinical follow up, and medication documentation.

## 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 demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumers’ rights is provided to residents and families during the admission process. The residents' cultural, spiritual and individual values and beliefs are assessed on admission and are being met by the service. Evidence-based practice is evident, promoting and encouraging good practice. Residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. Business goals are documented for the service with evidence of regular reviews. A system is in place for the collation, trending, analyses and evaluation of quality and risk data. Preventative measures are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

There are human resources processes in place around recruitment, selection, orientation and staff training and development. The education and training programme covers relevant aspects of care and support. Careerforce training is supported. The staffing policy aligns with contractual requirements and includes skill mixes. Resident files are integrated and include notes by the GP and allied health professionals.

## 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. |

An information pack is available to the resident and family/whānau prior to entry or on admission. Assessments (including InterRAI) and support plans reviewed were developed and implemented within the required timeframes. The residents' needs, and objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly or earlier if there was a change to health status.

The activity programme is resident-focused and provides group and individual activities planned around everyday activities such as walks, setting tables, craft and gardening. Volunteers assist with this programme.

There are medicine management policies and procedures in place. Medication is managed in-line with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The company dietitian reviews the five weekly menus. Food is cooked off site at a sister facility. Food service staff are aware of residents’ likes/dislikes and alternative choices are offered.

## 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. |

The building has a current building warrant of fitness and maintenance is carried out. All rooms are single and personalised. All rooms share communal showers/toilets. There is adequate room for the safe delivery of rest home level of care within the resident’s rooms. Residents can freely access communal areas using mobility aids. There is a communal dining area, lounges and recreational areas plus small seating areas.

Outdoor areas are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment.

Emergency policies and procedures are in place to guide staff should an emergency or civil defence event occur. Extra supplies are readily available in the event of an external emergency or infectious outbreak. Fire drills take place six-monthly.

## 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 policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. The service had no residents using restraints or enablers. The topics around restraint minimisation, enabler use and challenging behaviour are included in the education and training programme.

## 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. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (the clinical nurse manager) is responsible for coordinating education and training for staff. There are a suite of infection control policies, standards and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 41 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 3 | 87 | 0 | 1 | 2 | 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 | Presbyterian Support Central (PSC) Reevedon Home has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on the Code at admission. Interviews with care staff (three healthcare assistants, one activities coordinator and one clinical nurse manager) reflected their understanding of the Code. Seven residents interviewed confirmed staff respect their privacy and support them in making choices. No families were available to be interviewed. |
| 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 | There are informed consent policies and procedures for staff to follow. Residents and their families are provided with all relevant information on admission and staff hold discussions regarding informed consent, choice and options regarding clinical and non-clinical services. The consent form states that the resident may withhold or decline to consent for any specific procedure. Staff interviewed were knowledgeable in the informed consent process. Six resident files sampled had appropriately signed resuscitation forms.  There were six admission agreements sighted and all signed appropriately. Discussions with residents identified that the service actively involves them in decisions that affect their lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code and information about advocacy services on entry. Interviews with the facility manager and the clinical nurse manager confirmed this occurs. Interviews with residents confirmed that they are aware of their right to access advocacy and that there are opportunities to be involved in decisions.  A resident advocate has been appointed and was interviewed. She is responsible for listening to residents’ concerns and presents these concerns at the senior team meetings. She reported that residents’ concerns are addressed and gave examples of actions taken.  The residents’ files include information on residents’ family/whānau 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 | Families are encouraged to be involved with the service and care. The activities programme encourages links with the community (link to CI 1.1.3.6 and CI 1.3.7.1). Interviews with staff confirmed that residents are supported and encouraged to remain involved in the community. Visitors can visit at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives during their entry to the service. The facility manager, using a complaints register, maintains a record of all complaints. Two complaints received in 2015 (year to date) were reviewed and reflected evidence of responding to the complaints in a timely manner. The facility manager has signed one of these complaints off as resolved and the second complaint remains under investigation.  Complaints are linked to the quality and risk management system.  Discussions with residents confirmed that they were provided with information on complaints during their entry to the service. Complaints forms are located in a visible location at the entrance to the facility. Residents confirmed that they are comfortable speaking with a manager if they have a concern and that concerns are dealt with promptly. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code posters and brochures are displayed publicly. The information pack given to prospective and admitted residents and their families include pamphlets on the Code and the Health and Disability Advocacy Service. The admission agreement contains information relating to consumer rights. Interviews with residents confirmed that consumer rights were explained during the admission process. They also confirmed that residents’ rights are being upheld by the service. Residents’ meetings provide opportunities to discuss aspects of the Code. |
| 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 | Interviews with staff and residents confirmed residents are given support and encouragement to maintain their independence. A physiotherapist is on-site for two hours per week. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms. Appropriate signage and locks are on toilet and shower doors.  The abuse/neglect policy includes definitions and the process for reporting to ensure resident safety. Abuse and neglect training is a mandatory in-service topic. Discussions with the managers and staff identified that there have been no reported incidents of abuse or neglect. Staff are trained to report any concerns and could describe aspects of abuse and neglect.  Instructions are provided to residents/relatives on entry regarding responsibilities around personal belongings, in their admission agreement. Personal belongings were seen in resident rooms. The service encourages residents to have choice where able, such as voluntary participation in daily activities (link to CI 1.3.7.1). |
| 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 | Reevedon Home uses the PSC Māori Health Plan. On the day of the audit, one resident identified as Māori. This Māori resident has an individual care plan that identifies cultural needs specific to that person. These are based on comprehensive assessments and consultation with the resident and their whānau. The service has advised that they can access the Māori Health Advisory Unit, based at MidCentral DHB in Palmerston North. Interviews with all residents confirmed that the service provides a culturally safe service. |
| 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 | A culturally appropriate service includes assessing residents’ needs on admission. Six residents’ files reviewed identified that individual preferences, including cultural and spiritual values, were identified on admission and then integrated into the residents’ care plans. Families are invited to be part of the care planning process, and are given the opportunity to be involved in all aspects of care delivery.  Residents interviewed expressed their satisfaction with the services they are receiving. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The PSC Code of Conduct is included in the employee orientation pack. Job descriptions include responsibilities of the position. Signed copies of employment documents were sighted in all seven staff files reviewed (link to finding 1.2.7.4). The enrolled nurse works under the direction and delegation of the registered nurses (link 1.3.6.1). There are appropriate policies to guide staff practice. Interviews with all three healthcare assistants confirmed their understanding of the code of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. The managers and staff are committed to continuous quality improvement (CQI) processes. The Eden Alternative is embedded into practice (link 1.1.3.6).  Registered nursing staff are on-site five days a week and are on call when not on site 24 hours a day. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits scheduled for those residents whose condition is not deemed stable.  The service receives support from the MidCentral District Health Board. This includes (but is not limited to) access to the mental health team, infection control specialists, occupational and speech therapists, and nurse specialists. A physiotherapist is on site two hours per week.  There is a regular in-service education and training programme for staff meeting contractual requirements.  The service has maintained strong links with the local community and encourages their active residents to remain independent, with examples provided (link to CI 1.3.7.1). Residents interviewed spoke positively about the care and support provided. Care staff interviewed have a sound understanding of the principles of aged care and state that they are supported with their ongoing professional development. Registered nurses have paid study leave. If registered nurses can demonstrate relevance of training to the facility, consideration is also given to funding of the course.  Reevedon has a suite of policies and procedures that are updated as necessary. A quality improvement programme includes performance monitoring against clinical indicators separated into service type. Reevedon is benchmarked against other Presbyterian facilities and other facilities across NZ and Australia (link to CI 1.2.3.6).  Residents interviewed were positive about the care they receive. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy guides staff in their responsibility to notify family of any accident/incident that occurs. Accident/incident forms include a section to indicate if family have been informed (or not) of an accident/incident. Sixteen incident forms reviewed identified family were notified following an adverse event. Interviews with the registered nurse, enrolled nurse and healthcare assistants confirmed family are kept informed.  There is an interpreter policy and staff are aware of how to access interpreters if required.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Reevedon Home provides rest home level care for up to 42 residents. On the day of audit, there were 30 residents. All residents were under the Aged Related Care Contract.  A strategic framework is documented for Enliven PSC. Reevedon Home has a 2014 – 2015 business plan and a mission and vision statement linked to the strategic plan. The business plan outlines a number of goals and objectives, which are reviewed a minimum of quarterly with the regional manager.  The facility manager has been in the role at Reevedon Home for 18 months and has been a facility manager for PSC for five years. She is also responsible for one other PSC aged care facility in Levin and spends one morning a week onsite at Reevedon Home. She has 10 years of aged care management experience. The facility manager reports to a regional manager. The facility manager is supported by a full time clinical nurse manager/RN who has been in the role since January 2015 and a part-time (three days a week) quality coordinator/RN.  The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home. |
| 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 clinical nurse manager undertakes the facility manager’s role in her absence. Support is also available from the regional manager. During the absence of the clinical nurse manager, the facility manager bases herself at Reevedon Home and RN cover is provided by the quality manager/RN and from an RN from the other PSC aged care facility in Levin. |
| 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 | PSC has an overall quality-monitoring programme and participates in the QPS quarterly benchmarking programme. A quality coordinator/RN is appointed three days a week. There is evidence of data being collected, collated and analysed with results provided to staff via newsletters and on staff notice boards. The senior team meeting includes discussions around quality and risk. They meet every fortnight.  The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures cross-reference other policies and appropriate standards. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office and include procedures around InterRAI.  An internal audit programme is being implemented. Corrective actions are established and documented on a spreadsheet. Corrective actions are implemented and evaluated, with sign-off by the facility manager.  Annual resident and relative satisfaction surveys are undertaken with corrective actions implemented where indicated.  The organisation has a health and safety management system. Emergency plans ensure appropriate response in an emergency. There are risk management, and health and safety policies and procedures in place including accident and hazard management. PSC has achieved a secondary rating for ACC Workplace Safety Management Practice.  A comprehensive falls management programme has been implemented which has resulted in a gradual reduction in the number of falls by residents over a timeframe of four quarters. |
| 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 | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise future events and debriefing. Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Sixteen accident/incident forms were reviewed. Each event involving a resident, reflected a clinical assessment and follow-up by a registered nurse. Neurology observations were conducted for all suspected head injuries.  The managers are aware of their responsibility to notify relevant authorities in relation to essential notifications. There is evidence of one Section 31 Incident Notification form being completed in 2015 with appropriate actions taken. |
| 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 | There are organisational policies to guide recruitment practices and documented job descriptions for all positions. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates for the registered nurses, enrolled nurses, pharmacists, podiatrist, physiotherapist, dietitian and GPs are held on file.  Seven staff files were reviewed. Performance appraisals have been conducted annually. A general orientation programme is in place that provides new staff with relevant organisational information for safe work practice. There is an implemented specific RN orientation book and RN competencies are completed. RNs and ENs attend two PSC professional study days a year (as a minimum) that cover the mandatory education requirements and other clinical requirements. Also sighted was a job specific induction programme for the activities coordinator. Missing was documented evidence of job specific training for the healthcare assistants.  The organisation has a training framework for staff. All individual records and attendance numbers are maintained. External education and Careerforce training is supported. Contractual requirements are being met. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The facility manager works full time and is on-site for one day, four hours a week. She spends her remaining time at the other PSC facility in Levin.  The clinical nurse manager and quality coordinator are registered nurses who are available during weekdays. The RNs from the other PSC aged care facility in Levin, (which includes hospital-level services) are the first point of contact via telephone in the absence of the onsite RN. (Note: the clinical nurse manager lives greater than 30 minutes away from the facility). In the event of an emergency, the local paramedics are contacted.  Sufficient numbers of healthcare assistants supports RNs. Interviews with the residents confirmed staffing overall was satisfactory. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is developed in this time. The RNs have completed InterRAI assessments for all the residents who have been at the facility longer than three weeks.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in secure metal filing cabinets. Archived records are stored securely in a locked garage on the premises. |
| 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 | All residents are assessed prior to entry for rest home level of care.  The clinical nurse manager is responsible for the screening of residents to ensure entry has been approved. An information booklet is given to all residents/family/whānau on enquiry or admission.  The clinical nurse manager and enrolled nurse interviewed were able to describe the entry and admission process. The clinical nurse manager completes all admission documentation and relevant notifications of entry to the service. Residents interviewed stated they received all relevant information prior to or on admission. The GP is notified of a new admission.  Six signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The clinical nurse manager, enrolled nurse and healthcare assistants interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, and GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant, are copied and sent with the transfer documents. These documents are placed in the yellow transfer envelope. An end of service checklist is completed on transfer or death of a resident. |
| 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 | Medications are stored appropriately in line with accepted guidelines. The supplying pharmacy delivers all pharmaceuticals, monthly regular and ‘as required’ blister packs. The returns are stored safely until collected. An EN checks all medications on delivery and completes a medication checking form. Any discrepancies are fed back to the supplying pharmacy. The clinical nurse manager, ENs and senior HCAs administering medications undergo a medication competency.  The medication trolley is kept in a locked room. All eye drops in use are dated. There are no standing orders. There are two self-medicating residents, who have completed the competency to self-administer medication. Twelve resident medication charts sampled identified all charts had photo identification, allergies/adverse reactions noted, and nine of 12 had ‘as required’ medications prescribed correctly with indications for use. Ten of the 12 administration records showed that medications are being administered as prescribed. One medication chart did not have all medications signed by the GP. There is a label used to indicate “duplicate name”.  Eight of 12 medication charts reviewed included three monthly GP reviews. The other four were new charts. |
| 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 | There is a food services policy and procedure manual. All food is cooked off site at the sister facility and transported to Reevedon in hot boxes. The company dietitian reviews a five-weekly summer and winter menu. Resident birthdays and special occasions are catered for. All residents have a dietary requirements/food and fluid chart completed on admission.  The cook maintains a folder of residents’ dietary requirements that includes likes/dislikes. Alternatives are offered and alternatives are provided at every meal to ensure there is choice available if a meal delivered is not to a resident’s liking. The offsite cook (interviewed) is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals, a gluten free diet and diabetic diets. Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirm likes/dislikes are accommodated and alternatives offered. Daily hot food temperatures are taken and recorded for each meal at the time they are delivered and there are facilities to reheat meals if they are not at the required temperature. Food is then transferred to a portable bain marie that is used to deliver foods to the dining room. Fridge and freezer temperatures are recorded daily for the kitchen appliances and weekly in the lounges, with the lounge fridges also having an alarm that alerts if the temperature is outside the required range. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen is clean and has a good workflow. Chemicals are stored safely and safety data sheets are available. Personal protective equipment is readily available and staff were observed to be wearing hats, aprons and gloves. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurs. Potential residents are then referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The six resident files contained an initial assessment that was undertaken on the day of admission followed by an InterRAI assessment, a falls, pressure risk, continence, pain and nutrition and fluids assessment within three weeks of admission. These assessments were undertaken at least six monthly or as needs change and served as a basis for care planning. The activities coordinator completes an activity assessment. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The clinical nurse manager develops the long-term support plan from information gathered over the first three weeks of admission.  The support plans reviewed reflected the outcomes of risk tool assessments. InterRAI CAPs and triggers were also well linked. Interventions clearly described the support required. Each resident file sampled had a risk summary form at the front of their file detailing the resident’s medical problems and alerts such as high falls risk. There was documented evidence of resident/relative/whānau involvement in the support planning process.  Files sampled contained short-term care plans to document any changes in health needs with interventions, management and evaluations. Short-term care plans are templated for chest, urinary and ear infections, nutritional needs and wounds. Short-term care plans sighted included management of UTI, chest infection, skin infection and wounds. Short-term care plans reviewed had been evaluated at regular intervals.  Medical GP notes and allied health professional progress notes were evident in the residents integrated files sampled. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The clinical nurse manager completes residents’ support plans. When a resident's condition alters, the clinical nurse manager or enrolled nurses initiate a review and if required, GP or specialist consultation.   Dressing supplies are available and the treatment room well stocked. All staff report that there are adequate dressing supplies and adequate continence products. Specialist wound and continence advice is available as needed through the DHB and the wound and continence product representative. A health status summary held in the resident’s record, records any significant events, investigations, GP visits and outcomes.  One assessment, management plan and ongoing review were sighted for one resident with three minor wounds. There were no other wounds at the facility on the day of the audit. The wound had well documented wound progress notes and evaluations. There was a short-term care plan in place for the wounds.  Behaviour charts, food and fluid charts, fluid balance charts and weekly weighs were sighted to be appropriately completed for residents with related needs. Progress notes are documented at least daily by the healthcare assistants and most days by an enrolled nurse. However, files sampled do not demonstrate documented registered nurse follow-up of all identified issues. |
| 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. | CI | An activities coordinator has been in the role for one year and works 30 hours per week over five flexible days (that can include evenings). She has completed Eden alternative training. The organisation has gained six Eden principles accreditations (link to CI 1.1.3.6).  The weekly activity programme has significant resident input and has a range of activities to meet most needs including entertainment, craft, walks, memory games, music and DVDs. There are also van outings. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme. The pictorial programme is displayed on noticeboards and delivered weekly to all residents, by other residents.  Residents, families and staff celebrate special events such as birthdays, mother’s day and Anzac day. There is a spring ball planned for this month.  With the introduction of Eden there is also a focus around meaningful everyday activities such as gardening, baking, reminiscing, feeding cats and birds, gardening, walking, tidying drawers and making own beds (if able). Volunteers support the programme.  The service has exceeded the required standard around the provision of a meaningful activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The files sampled evidenced six monthly multi-disciplinary team (MDT) evaluations of the support plan. The long-term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. InterRAI evaluations and other risk assessments were completed within the appropriate timeframe. Short-term care plans reviewed were evaluated regularly with problems resolved or added to the long-term support plan if an ongoing problem. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of residents’ files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, physiotherapist and mental health service.  There is evidence of GP discussion with families regarding referrals for treatment and options of care. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Chemical supplies are kept in locked cupboards in service areas. A chemical spills kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current building warrant of fitness, which expires 28 February 2016. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. Hot water temperatures are monitored.  The maintenance person is a contractor and employed two days per week but is available for emergencies afterhours. Preferred contractors are available 24/7. The maintenance person carries out minor repairs and maintenance. A contractor maintains the grounds. The maintenance request book is checked and signed-off, as requests are actioned. Electrical equipment is tested and tagged. Clinical equipment is calibrated annually.  The corridors are carpeted. Bedrooms are either carpet or vinyl. Vinyl surfaces are in all bathrooms/toilets and the kitchen. Corridors are wide and there are handrails in all corridors, promoting safe mobility. Residents were moving freely around the areas with mobility aids where required. There are external areas and gardens, which are easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas. There are adequate storage areas for the hoist, wheelchairs, products and other equipment. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. There is a designated external smoking area. |
| 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 | All rooms use communal showers/toilets. There are adequate communal showers/toilets and they are conveniently located close to service areas. There are separate toilets for staff and visitors. All showers//toilets have appropriate flooring and handrails. There are privacy locks and shower curtains. Call bells are available in all shower//toilet areas. |
| 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 resident rooms in the facility are single and of an adequate size for rest home level of care. The bedrooms allow the residents to move about independently with the use of mobility aids. The bedrooms have sufficiently wide enough doors for ambulance gurney entry/exit. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed confirmed their bedrooms are spacious and they can personalise them as they wish. |
| 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 facility has a separate large dining area and activities lounge. Additionally there are several smaller lounges and nooks to create a more home like environment. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. The wide corridors are light and spacious and have seating and small tables placed to create other small lounging areas. Residents were moving safely between the communal areas with the use of their mobility aids. There is adequate space to allow for individual and group activities to occur. |
| 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 | All linen and personal clothing is laundered off site. Adequate linen supplies were sighted. Afternoon healthcare assistants deliver clothing to the rooms. Chemicals are stored in a locked chemical room.  There are cleaners on duty each day for the facility. The cleaner’s cupboard containing chemicals is kept locked. All chemicals have manufacturer labels. The cleaning trolley is well equipped and stored in a locked area when not in use. Cleaning staff were wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. The residents interviewed were satisfied with the cleanliness of the communal areas and their bedrooms. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Civil defence and emergency policies and procedures are in place. Civil defence kits are readily accessible. A register of all residents’ details is held. There is an approved evacuation plan. The facility is well prepared for civil emergencies. A store of emergency water is kept. There is a gas BBQ for alternative cooking. Emergency food supplies are sufficient for three days. Extra blankets are available and emergency lighting is in place.  The electronic call bell system is available in all areas. Residents have easy access to the call bells. Residents interviewed stated their bells were answered in a timely manner. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and maintained at a comfortable temperature. Residents interviewed confirmed the environment and the bedrooms are warm and comfortable. |
| 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 | The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. There is an external benchmarking system in place and summaries of these results are fed back through the senior team. The scope of the infection control programme policy and infection control programme description is available. The infection control (IC) coordinator is the clinical nurse manager (a registered nurse) who has been in the role since January 2015. The previous IC coordinator (the quality coordinator) supports her. The senior team meeting and the governing body are responsible for the development of the infection control programme and its review.  Suspected infections are confirmed by laboratory tests and results are collated monthly. There are policies and procedures in place around when an outbreak of infection occurs. |
| 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 | Infection control meetings are combined with senior team meetings. The infection control coordinator is booked to attend IC training days (post grad level 7 IC course by CPIT) within the organisation for the role in February. The previous IC coordinator, who has completed external training in infection control and has attended the regional IC meetings, currently supports her. The facility also has access to an infection control nurse specialist, public health and GPs. |
| 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 care and support manual outlines a comprehensive range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The previous infection control coordinator has maintained her skills and knowledge of infection control practice through attendance at PSC training and DHB regional IC group meetings. This role has been handed over to the current IC coordinator who is attending IC training at PSC in February 2016. Infection control education is part of the professional nurses and HCA study days that are held annually. A recent hand hygiene audit has been completed. The clinical nurse manager described IC education/reminders provided during handovers to staff. |
| 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior team meeting (link to CI 1.2.3.6). The meetings include the monthly infection rates. Individual resident infection control summaries are maintained. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. Interviews with the healthcare assistants and nursing staff confirmed their understanding of restraints and enablers.  Enablers are assessed as required, for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had no residents using enablers or restraints.  Restraint minimisation and enabler education and training is in place for all care staff. |

# 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 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | An orientation programme is in place that provides new staff with relevant information for safe work practice. Staff interview confirmed completion of orientation including a buddy system for orientating new staff. Evidence of job-specific orientation being completed were sighted for the activities coordinator, clinical nurse manager and one healthcare assistant but were missing in four other healthcare assistants’ files. | Four of five healthcare assistants’ files did not hold documented evidence of orientation training specific to their job role. Staff interviews confirmed that healthcare assistants have three days allocated for orientation and are buddied with a senior healthcare assistant during this time. | Ensure evidence of job-specific orientation is documented for the healthcare assistants with evidence retained in staff files.  90 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 | Medications are stored in the treatment room in the blister pack folders, the cupboard or the fridge. The medication trolley is taken to each room when medication is being administered. The enrolled nurse witnessed administering teatime medications followed correct process. Two of the twelve charts sampled had prescribed medications that were not signed as administered. All residents have a medication chart and on nine of the twelve charts sampled, a clear indication for use had been documented for each ‘as required’ medication prescribed. One medication chart was not fully completed by the GP. | Two of ten medication administration records sampled did not have all prescribed medications consistently signed as administered.  One of twelve medication charts had a medication on the chart without a doctor’s signature.  Three of twelve medication charts did not have the indication for use for ‘as required’ medications documented by the prescriber. | Ensure medications are administered as prescribed.  Ensure all medications are signed by the prescribing doctor.  Ensure that an indication for use is documented for all ‘as required’ medications.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The service has a comprehensive wound assessment form and a separate wound management document. One form was completed for three current wounds for the only resident with wounds. The wounds are minor in nature. Healthcare assistants document interventions completed in progress notes at least daily and more often if there is a variation in the resident’s routine or condition. Enrolled nurses frequently assess residents and document this. There is not always a documented review by the clinical nurse manager (the registered nurse) when issues are identified. | One resident has three minor wounds all documented on one assessment and management plan.  Six of six files sampled have occasions where issues documented by enrolled nurses or healthcare assistants in the residents’ progress notes did not have documented registered nurse assessments/follow up. | Ensure every wound has an individual assessment and management plan.  Ensure that a registered nurse reviews residents when there is a change in health status and that this is documented.  60 days |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.3.6  Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer. | CI | The facility over the past year has embedded the Eden Alternative in 2015 with significant outcomes achieved. | The Eden Alternative is embedded into practice with positive outcomes achieved. A recent Eden Alternative audit resulted in the achievement of six of ten Eden principles. They were the first facility in New Zealand to meet this many principles for their first audit. Areas of excellence included the following:  Principle 3 – Forming close and continuous contact with children. Afterschool reading programme with Kopotoroa School. Weekly visits to Levin School ‘Adopt a class’ programme. Formation of a mothers group where mothers with babies visit the facility weekly.  Principle 4 – Resident native seed raising group established to raise and donate native plants back to the community.  Principle 5 – Spontaneity and variety through improvements to the residents’ social calendar and empowering staff.  Principle 6 – Meaningful activities (link to CI 1.3.7.1).  Principle 7 – Removing medication administration during dining room service enhancing the dining experience for residents. First person care plans and inclusion of photos. In depth ’Loneliness, Helplessness and Boredom’ support plans. Surveying residents ‘Domains of Wellbeing’ and implementing action plans to further enhance outcomes.  Principle 8 – Resident involvement in senior team meetings and recreation planning.  Resident satisfaction survey results reflect significant gains in the following areas: activities and lifestyle (69% (2014) and 86% (2015); medical and therapy services (74% 2014) and 85% (2015); communication and social involvement (69% (2014) and 83% (2015); maintaining community contact (79% (2014) and 88% 2015).  The managers attribute these positive results to the implementation of the Eden Alternative. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | There are quality and risk management processes in place. The service-monitoring programme includes infection control, quality improvement, service delivery, resident rights, managing service delivery, emergency and human resources.  The service completes an internal audit for each area, which results in a report that identifies criteria covered and achievements, a general summary of the audit results, key issues for improvement and an action plan for resolution.  A comprehensive falls prevention programme has resulted in a significant reduction in falls over a timeframe of five quarters as documented on the QPS Benchmarking report. | It was identified over a two-quarter period that falls had increased, peaking in September 2013 at 118%. The facility planned an improvement project to reduce falls through a number of strategies. The initiatives and strategies led to positive outcomes with a continued decline in fall rate over a 5-quarter period and performing well below the industry benchmark. QPS Benchmarking and the PSC Quality and Innovation awards have recognised this achievement.  The last two quarters have seen a slight rise in falls, which directly related to one resident who is falling frequently. A number of initiatives have been implemented for this resident to assist in maintaining their level of independence (link to tracer). This was also confirmed when reviewing accident and incident forms for the facility. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The activities programme is developed monthly at the residents meeting with activities being determined by the residents. Groups include a gardening club, a knitting club, a men’s club, a hand bells group and a café provided by volunteers. | The service provides a comprehensive activities programme with significant input from residents that exceeds the required standard. Following the September 2014 residents’ survey result of 69% satisfaction with activities and lifestyle the facility identified the need to improve in this area. A number of initiatives were introduced, including (but not limited to) residents having significant input into the review of and development of the activities programme, the introduction of an ‘adopt a classroom’ scheme where a resident visits the same classroom monthly for a year. The introduction of a reading club where 12 students (the same students for a tem) visit after school, have afternoon tea and practice reading with residents and a men’s club which has resulted in increased attendance by men and one wing having only one woman in it as men have chosen to reside together. In July 2015, the service held a ball with 80 guests. Each resident was able to invite one guest. Volunteers donated ball dresses and suits, makeup, tome, lighting, decorations and wine. Following the introduction of these initiatives as part of the introduction of the Eden principles (link CI 1.1.3.6), satisfaction in the September 2015 survey around activities rose to 86%. Additionally the domains of wellbeing in the Eden Alternative survey in 2015 showed very high satisfaction with three domains at 100% and two domains at 96%. |

End of the report.