# New Zealand Lakeside Group Limited - Elizabeth Retirement Home

## Introduction

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

The audit has been conducted by Health Audit (NZ) 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:** New Zealand Lakeside Group Limited

**Premises audited:** Elizabeth Retirement Home

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

**Dates of audit:** Start date: 31 March 2016 End date: 1 April 2016

**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:** 23

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

Elizabeth Retirement Home is a 26 bed facility for rest home level of care residents. The provisional audit was undertaken to establish the prospective provider’s preparedness to provide a health and disability services and the level of conformity with the required standards of the existing owner’s services.

The audit was conducted against the relevant Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, resident files, observations, and interviews with residents, family/whanau, management, staff, a general practitioner and the prospective provider.

There are no areas for improvement at this audit with no systemic issues identified that require corrective actions to be implemented.

The prospective provider has demonstrated knowledge of the requirements for running an aged care service and has employed an experienced clinical manager.

## Consumer rights

The residents receive service that respects their rights. The current staff and prospective owner demonstrated knowledge and commitment to their obligations of consumer rights legislation. The residents are treated with respect, dignity and are not subject to abuse neglect or discrimination.

There are appropriate processes and procedures implemented to ensure residents who identify as Maori, or any other culture, have their individual beliefs respected and acknowledged. If required, the service can access an interpreter.

The service provides an environment that encourages good practice, which should include evidence based practice.

Residents and families receive full and frank information and open disclosure from staff. The residents, their families or enduring power of attorneys (EPOAs) are involved in the care planning, decision making and consent processes. Where there is an advance directive, the staff act on the decisions.

There are no set visiting hours and residents have access to visitors of their choice. All visitors commented on the welcoming nature of the service.

The service has a documented complaints a management system which was implemented. There were no outstanding complaints at the time of audit.

## Organisational management

The current owners and a management have a business and quality plan in place. The organisation’s mission statement, vision, goals and philosophy identifies the organisation’s mission statement, vision and philosophy. The prospective provider plans to continue with current systems and has a transition plan for taking over the management and running of the service.

The current quality and risk system and processes support safe service delivery and include corrective actions. The quality management system includes identification of hazards, staff education and training, an internal audit process, complaints management, data reporting of incidents/accidents and infections. The day to day operation of the facility is undertaken by non-clinical and clinical staff who are appropriately experiences and/or qualified. This allows residents’ needs to be met in a safe and efficient manner, as confirmed during resident and family/ whanau interviews and in the 2015 satisfaction survey results.

Policies and procedures are developed by an external aged care consultant and the prospective provider intends to maintain these policies. The policies reflect current accepted practice.

The service implements the documented staffing levels and skill mix. The rosters record that there are adequate staff each shift to comply with contractual requirements. All shifts are covered by at least one staff member who has a current first aid qualification. Human resources management and education processes are implemented and identify good practice is observed. The prospective provider demonstrated a good understanding of human resources requirements and meeting contractual requirements and resident’s needs.

Resident information is uniquely identifiable, accurately recorded and securely stored. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

## Continuum of service delivery

Registered nurses are responsible for the development of care plans with detailed input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractually requirements.

Planned activities are appropriate to the residents’ assessed needs and abilities. In interviews, residents expressed satisfaction with the activities programme in place.

A medication management system is in place and medication is administered by staff with current medication competencies. All medications charts are reviewed by the GP every three months.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

Services are provided in a clean, safe, secure environment that is appropriate to rest home level of care. There are appropriate amenities to meet residents’ needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Laundry services are contracted to an off-site provider. There are adequate toilets, showers, and bathing facilities.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness. Planned and reactive maintenance is documented. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan.

All residents have access to outdoor areas with shaded areas

The prospective provider does not plan to make any major changes to services or environmental areas. If any changes are to be made to update and renovate the services, these will be reflective of legislative requirements.

## Restraint minimisation and safe practice

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive continuous restraint education.

## Infection prevention and control

Infection control and prevention management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff.

Infection data is collected, analysed monthly and reported to staff and management in a timely manner. Infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 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).

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| --- | --- | --- |
| **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 and brochures are available throughout the facility. Staff demonstrated knowledge of the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The Code is discussed with family members as part of the pre-admission and admission processes. Information about the Code is also available in the information booklet. The resident information booklet is available in each resident’s room and contains information about the Code. New residents and families are provided with copies of the Code as part of the pre-admission and admission process. The Code is available in different languages.Information was also displayed about the Nationwide Health and Disability Advocacy Service. The residents and families reported no concerns about staff not respecting the resident’s rights. The residents reported that management is very open to hearing about any concerns and these can be also brought up at the monthly residents meeting (no concerns recorded in the meeting minutes sighted). The prospective owner’s representative demonstrated awareness of the Code and how it relates to resident care and service delivery. |
| 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 | All rooms are single occupancy at the time of audit. There is one room that is large enough to be used as a double room for couples. There are privacy locks on the bathroom facilities.The files reviewed reflected that care is provided that is responsive to the individual cultural and spiritual needs of each resident. Services are planned so the residents can maintain as much independence as possible. The relatives reported satisfaction with the care provided and have no concerns about abuse or neglect.Staff receive ongoing education on how to identify and what to do it they suspect abuse or neglect. Staff demonstrated knowledge on identifying any suspected abuse and know who to report to if they suspect abuse or neglect. |
| 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 | Residents who identify as Maori have their individual needs met. Care assessment and planning is based on Te Tapa Whare. Policies, procedures and individual care plans provide guidance on delivering culturally safe practice and reflect the Treaty of Waitangi expectations. The Code and Treaty of Waitangi are displayed in English and Te Reo.There are a number of residents that identify as Maori. The quality assurance manager reported that there were no barriers to Maori residents accessing the service.Staff demonstrated knowledge of the importance of whanau in the care and support of residents who identify as Maori. The Maori residents interviewed reported satisfaction in the manner in which care and services are provided. |
| Standard 1.1.6: Recognition and Respect Of The Individual’s Culture, Values And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs | FA | The resident’s individual cultural values and beliefs were recorded in the care plans. All files evidenced the care was developed in consultation with the resident, and where relevant, the family. The relatives interviewed reported that the service meets the individual needs of their relatives. Staff demonstrated knowledge in respecting and meeting the individual cultural needs, values and beliefs of each of the residents. There are residents and staff of varying cultural backgrounds at the service. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Individual employment contracts, house rules and policies have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whanau reported they have no concerns about discrimination. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP and links with other health providers such as mental health services, Maori Health providers and palliative care services.There is regular in-service education and staff access external education that is focused on aged care and best practice. When staff attend external education sessions, they disseminate this information to other staff and health professionals. The RN is a member of the gerontology section of the nurse’s organisation. Recent education has included topics on pressure injury prevention. Staff reported that they were satisfied with the relevance of the education provided. The residents and family/whanau expressed high satisfaction with the care delivered. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service promotes an environment that optimises communication through the use of interpreter services as required. The residents are able effectively communicate with staff. Policies and procedures are in place if the interpreter services are needed to be accessed. The Code is available in a variety of languages and the service has access to cue cards of common words/sayings to assist in communicating with a resident if the resident does not speak English. There is one resident that has English as their second language and for care planning reviews and GP visits the family are present to assist with interpreting more complex issues, terms and seek clarification of the residents understanding of what is being discussed. Staff education has been provided related to appropriate communication methods.Documentation of open disclosure following incidents/accidents is evident. The monthly residents meeting provides an opportunity for bringing up any issue. |
| 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 residents' files reviewed had general consent to care forms signed by the resident or their next of kin/enduring power of attorney (EPOA). It is recorded in the resident’s file and on a register if the EPOA has been activated. There are specific consent forms for other medical procedures or invasive procedures (with this process managed by the GP). The consent forms are reviewed at least annually and management and staff are aware that the resident can withdraw consent at any time.The service has been conducting a quality project and providing information to residents, relatives and staff on advance care planning. Information on Advance Care Planning (ACP) is also discussed at the residents meeting and information is provided in the newsletters. The nursing care plans sighted do record if the resident has any wishes for end of life care.Staff acknowledged the resident's right to make informed choices and respecting any end of life wishes (including knowledge of culturally appropriate end of life care). Residents and family expressed no concerns related to informed consent. |
| Standard 1.1.11 Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The residents and family/whanau reported that they were provided with information regarding access to advocacy services as part of the pre- admission and admission processes. There is a list of independent advocates displayed on the resident’s noticeboard. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is conducted as part of the in-service education programme. If the resident wishes, their family or any other advocate or support person are invited to the care and medical assessment and review processes. The residents and families did not express any concerns regarding access to advocacy and support. |
| Standard 1.1.12 Links With Family/Whānau And Other Community ResourcesC Consumers are able to maintain links with their family/whānau and their community. | FA | There are no set visiting hours and visitors are encouraged to visit. Residents are supported and encouraged to access community services with visitors. Residents were observed to be accessing the local community resources independently. The service has links with local schools, religious, marae and community activity services. Each resident room has the ability for a private phone line for the resident. |
| Standard 1.1.13 Complaint ManagementThe right of the consumer to make a complaint is understood, respected, and upheld. | FA | The sighted complaints policy and process complies with Right 10 of the Code. The complaints register identified complaints have been managed within policy time frames. The complaints register records all complaints, dates and actions taken. The complaint register also recorded what Right the complaint relates to There is an annual summary of the complaints that summarises the complaints, outcomes and any trends that may have been identified. There is one recorded complaint for 2015.Complaints management is explained as part of the admission process and is included in the information given to new residents and family/whānau. The monthly resident meetings and the newsletters reinforce the residents/relatives right to make a complaint and how to go about same. Complaints management is included in new staff orientation and included in ongoing training. Staff demonstrated knowledge of what to do if they receive a complaint.Family/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time. There were no open complaints at the time of audit. The prospective owner understands the consumer’s right to make a complaint. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service has a maximum capacity of 26 residents. On the day of audit 23 beds were occupied, all are rest home level of care and includes one younger person under the age of 65. The service has a business plan which identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs.Strategic planning is undertaken yearly to ensure the services offered meet residents’ needs. This is reflected in the business plan goals and objectives sighted which covers all aspects of service delivery. The business plan is reviewed at least annually to set new goals and objectives. There are management meetings at least quarterly to review progress with the set goals. The prospective provider does not intend to make any immediate changes to the current systems.The facility has been privately owned and managed by the same two people for over 26 years. They both work in the business full time, one being the owner/manager and the other the quality assurance and administration support. They are supported by a register nurse (RN) who works at least 24 hours a week and is on call as required. There are two other RNs who also work at the service. All members of management attend education appropriate to the role they undertake. Job descriptions identify management members’ experience, education, authority, accountability and responsibility for the provision of services.Residents and family/whānau, satisfaction surveys and resident meeting minutes confirmed that their needs are met by the service.The prospective provider has employed a nurse manager to take over the clinical management role. The new nurse manager will have the delegated authority and responsibility for all aspects of clinical management and service delivery. This person is a New Zealand registered nurse and has aged care management experience. The new nurse manager will be orientated to the role by the current manager in the week leading up to the handover date, as described in the transition plan. The current management team reported they will provide support after this ‘for as long as they feel necessary’ (with the current management team also being available onsite for at least the first week and available for offsite support and advice after the transition period). Any changes that are to be made will be compliant with the obligations of the standards and DHB contractual requirements. The current management team expressed confidence in the prospective provider and the selected nurse manager to effectively manage the service to meet the resident’s needs, standards and contractual requirements. |
| 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 | Currently during a temporary absence of the manager the RNs take on the manager’s roles. The manager reports confidence in the staff’s ability to take on the management role during temporary absences. The prospective provider intends to employ and contract other registered and enrolled nurses to assist with taking up the nurse manager’s role during temporary absences. |
| 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 | Quality and risk management systems are clearly documented and identify outcomes of quality improvements/projects. The service has a quality and risk management system which is understood and implemented by service providers. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. All corrective actions are reviewed and evaluated. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Information collected informs ongoing planning processes to ensure residents’ needs are met.The policies and procedures are developed by an aged care consultant and personalised to the rest home level of care service. Policies are reviewed at least annually, with input from the quality assurance manager, owner/manager and registered nurse. Staff only have access to the current policies, with staff updated on any changes in policy through staff meetings and the staff notice board. There is an archive system in place for obsolete documents.The key components of service delivery are standing agenda items for management and staff meetings. All data is collected monthly, collated, trended, reviewed by management and corrective actions put in place if any deficits are noted. Each key component has a set quality goal which is regularly reviewed and evaluation is documented to indicate how improvements have impacted on resident satisfaction and/or safety. Information is used to inform business and strategic planning processes Staff, resident and family/whānau interviews confirmed any concerns raised have been addressed by management and verbal examples of quality improvements were given.There is monthly and annual collation, analysis and evaluation of the quality data. The information is shared with staff, residents and family/whānau as appropriate. This includes information being published in the newsletter. The service has also contributed to external quality data on falls and pressure injury reduction through the DHB.Clearly documented information is available to all staff and the continued improvement process is over seen by management. Staff, residents and family/whānau interviewed confirmed they feel included and well informed about any new processes put in place. Some recent quality initiatives include the review of the medication charting system, focus on skin care and recording of the application of topical treatments, advance care planning and the use of the Glasgow Coma Scale after a resident has had a fall.Corrective action processes inform the quality goals to ensure residents’ needs are being met. Corrective action plans have been developed from all quality processes where a deficit has been identified and/or to related to ensuring best practice standards are maintained following staff education or to meet legislative requirement changes. The corrective actions are decided by the management team and shared with staff at handover and at staff meetings. As staff implement the actions, their input into the evaluation of corrective measures taken is documented and discussed. If a corrective action appears not to be working, then actions are changed so the service can reach their required quality goals. This process is clearly documented.Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.The prospective provider intends to maintain the current systems for quality and risk management. |
| 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 | Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified. The service provider fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. The service is aware of their responsibility to report stage 3 and above pressure injuries (this is documented in the pressure area injury policy with links to the section 31 reporting form).Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required.Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. Family/whānau report they are notified of any adverse, unplanned or untoward events. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. The service has met all Accident Compensation Corporation (ACC) workplace safety requirements and has a valid certificate to 2017.The prospective provider understands their responsibilities for essential notification and incident/accident reporting and intends to maintain the current incident/accident reporting system. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Staff that require professional qualifications have them validated as part of the employment process and annually. A register is maintained of when the annual practicing certificates are due for renewal. A copy of the current APC is sighted for all staff and contractors, who require them.Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Staff files showed that upon employment references are checked and job descriptions clearly described staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles, which are then repeated annually, as confirmed during staff files reviewed. The staff files confirmed performance reviews are conducted initially at six weeks, three months, six months and then annually.Staff undertake training and education related to their appointed roles. Staff education includes on site guest speakers, off site seminars and training days to ensure all aspects of service provision are met on a two yearly schedule, this includes ongoing education on pressure injury prevention. Staff education as part of the in-service education programme and is conducted monthly after the staff meeting. This was confirmed in the education records sighted for 2015 and to date in 2016. The service has an adequate amount of RNs that are trained and assessed as competent to conduct the interRAI assessment tool.Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents’ needs are met by the service.The prospective provider understands the need for ongoing education for all staff and plans to continue with the existing programme. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider’s contract with Auckland District Health Board. Additional staffing hours are put in place as required. There is at least one care staff member on duty and one care staff member on-call at all times. The service has more than one RN, whose roles include the provision of the clinical aspects of care (assessment, care planning, review, and evaluation), assist in the review and development of clinical policies and procedures, liaises with medical staff and advises on, and provides the required education to the care staff.A review of staff rosters identified that at least one staff member on each shift has a current first aid certificate (sighted).Both owner/manager and quality assurance manager work at the facility and provide cover seven days a week. There is a system in place for on call medical and registered nursing cover. This system is understood by staff. All caregivers interviewed report that there is adequate staff available and that they are able to get through their work.Residents and family/whānau members interviewed report that there is enough staff on duty to meet their needs.The prospective provider does not intend to make any change to the caregiving rosters. They have already engaged the services of a nurse manager and are looking at additional RNs and ENs to ensure the needs of the residents are met. They demonstrated an understanding of their obligations to meet contractual requirements, and if any changes to staffing levels are made, these will be maintained to meet contractual requirements. |
| 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 identified that information is managed in an accurate and timely manner. Health information was kept in secure areas in the staff area and these were not accessible or observable to the public. There is no private information on display in the facility. All records pertaining to individual residents demonstrated they are integrated. The archived records are securely stored onsite.The resident’s progress notes have entries each morning and afternoon shift and recorded the staff member’s signature. A signature verification log is also kept. |
| 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 | The entry to service policy has all the required aspects on the management of enquiries and entry. Elizabeth Retirement Home’s welcome pack contains all information about entry to the service. Assessment and entry screening processes are documented and clearly communicated to residents, their family/whanau of choice where appropriate, local communities and referral agencies.Admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Residents interviewed confirmed that they received sufficient information regarding the service to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The standard transfer form notification from the district health board is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| 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 | The medicine management system is implemented to ensure that residents receive medicines in a safe and timely manner. All medications are reviewed as required and discontinued medications were signed and dated by the GP, allergies were documented, and photos present and three monthly reviews are completed. Medication charts are legibly written. The Health care assistant who is competent to give medications was observed administering medications correctly. Medications and medication charts are stored safely and securely and medication reconciliation is conducted by the RNs when the resident is transferred back to service.The service uses individualised blister packs that are checked by the RN on delivery. The controlled drug register is current and correct. Weekly stock takes are conducted and all medications were stored appropriately. There is one resident who self-administers only inhalers and was assessed as competent. Self-administration policies and procedures are in place. An annual medication competency is completed for all staff administering medications and medications training records was sighted. The medication management system complies with legislation, protocols and guidelines. |
| 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 | Meal services are prepared on site and served in the nearby dining room. The kitchen staff have current food handling certificates. The menu was reviewed by a registered dietitian to confirm it is appropriate for the nutritional needs of the residents. Diets are modified as required and the cook confirmed awareness on dietary needs required by the service. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. The resident’s weight is monitored regularly and supplements are provided to residents with identified weight loss issues.The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family interviewed indicated satisfaction with the food service. The satisfaction survey indicated that residents are happy with the meals provided. |
| 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 manager reported that they have never declined any prospective client entry but do have an outcome section on the pre-entry enquiry book to record. When a resident is declined entry, family/whanau are informed of the reason for this and other options or alternative services available. The resident is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessment is completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans were detailed and include input from the resident, their family/whanau and other health team members as appropriate.Registered nurses utilise standardised risk assessment tools on admission. In interviews, the residents expressed satisfaction with the support provided. |
| Standard 1.3.5: PlanningConsumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long term care plans were resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short term care plans for acute needs. Goals were specific and measurable and interventions were detailed to address the desired goals/outcomes identified during the assessment process. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations. |
| Standard 1.3.6: Service Delivery/InterventionsConsumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions were sufficient to address the assessed needs and desired goals/outcomes. The interventions in short term care plans developed were specific to the acute infections being treated. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily. Resident’s files had activities of daily living documented and completed daily. Monthly observations were completed and up to date. |
| 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 | Activities are appropriate to the needs, age and culture of the residents. The activity coordinator and diversional therapist develop an activity planner and daily/weekly activities are posted on the notice boards. The resident’s files have documented activity plans that reflect the resident’s preferred activities of choice. Over the course of this audit, residents were observed being actively involved in a variety of activities and those interviewed expressed satisfactions with activities in place. The diversional therapist reported individualised activity plans are reviewed six weeks post formulation to evaluate effectiveness and six monthly or when there is noted decline in participation. The activities coordinator and diversional therapist reported that they have group activities and engage in one on one sessions with some residents and also have links with community organisations, churches and local schools. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident’s long term care plans were evaluated in a comprehensive and timely manner at least six monthly and updated if there is any significant change. Reviews were fully documented and included current resident’s status, any changes and achievements towards goals. Family/whanau and staff input is included in all aspects of care and is reviewed/evaluated. Short term care plans are developed as when necessary. |
| 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 | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All internal referrals are facilitated by the registered nurses and management team. |
| 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 | All chemicals are securely stored in the laundry storage area or cleaner’s cupboard. Chemicals are clearly labelled and safety data sheets are available. Staff confirmed that they can access personal protective clothing and equipment at any time. As observed, disposable gloves and gowns were worn when required. Waste storage and disposal meets legislative requirements. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current warrant of fitness which expires in September 2016.Maintenance is undertaken by both internal maintenance staff and external contractors. Current electrical safety test tags are evidenced on electrical equipment sighted. Clinical equipment is tested and calibrated at least annually or as required as per the manufacturer’s instructions. There is a monthly calibration of the scales. There is a documented process on the calibration methods. There is monthly inspection of other equipment such as laundry, kitchen and hot water temperature monitoring.The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, and walking areas are not cluttered. If any areas of concern are identified in the environmental audits the issue is placed in the hazard register if it cannot be eliminated. This identifies how the hazard is managed.There is access to external seating areas and gardens. Residents were sighted moving around safely both indoors and outdoors on the days of audit.Residents and family/whānau confirmed the environment is suitable to meet their needs.The prospective provider does not intend to make any immediate changes to the environment and is planning to maintain current systems. |
| 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 | Residents’ shower and toilet areas are centrally located. There are 13 rooms with ensuite toilets. The bathroom doors have privacy locks to ensure residents can attend to their personal hygiene without interruption. There are bathrooms and showers that have disability access. There is a designated staff/visitor toilet. |
| 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 single occupancy and are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. There is one double room that is large enough for a couple, though this is used for single occupancy at the time of audit. Bedrooms are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. Results from the relatives satisfaction survey and family/whānau members interviewed did not identify any concerns related to personal bed space or privacy. |
| 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 | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. The dining and lounge areas are separated. The areas are appropriately furnished to meet residents’ needs.Residents and family/whānau voiced their satisfaction with the homely environment. As observed, activities are undertaken in the lounge area. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are secure storage areas for cleaning and laundry equipment. The caregivers assist with the cleaning and laundry duties. The facility looked clean and was odour free, with residents and family commenting on how well the service is cleaned and their laundry is looked after. The cleaning and laundry processes are monitored for effectiveness through resident meetings and satisfaction surveys (residents and relatives). |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. There is an approved evacuation scheme. The service has not conducted any major renovations that have required the current evacuation scheme to be reviewed.The service has a civil defence kit, first aid kits and outbreak supplies. The service has adequate food and water for a minimum of three days. There are torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly. Fire suppression systems are maintained and inspected monthly by the external contractor.A call bell system is fitted throughout the service. The residents report satisfaction in the timeliness that the call balls are answered.The doors and windows are locked at night as part of the evening security. The back doors and back entrance to the facility is locked during meal times when residents and staff are in the front section of the building to assist with security during these times. There is a security camera system (CCTV) fitted in communal inside areas. The monitoring system for the CCTV is located in a secure upstairs staff area. |
| 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 | The facility is able to be maintained at a suitable temperature throughout the year by central heating and the opening of doors or windows for ventilation. All resident areas have at least one opening window to provide adequate natural light. This was confirmed during resident and family/whānau interviews. |
| 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 | Elizabeth Retirement Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The registered nurse is the infection control coordinator (ICC) and has access to external specialist advice from a GP and district health board infection control specialists when required.The infection control programme is reviewed annually and is incorporated in the monthly meetings and review of the education programme. Staff are made aware of the infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. There are processes in place to isolate infectious residents when required.A documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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 is responsible for implementing the infection control programme and indicated that there are adequate human, physical, and information resources to implement the infection control programme. Infection control reports are discussed at the management and monthly staff meetings, daily handovers as when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| 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 | Documented policies and procedures for Elizabeth Retirement Home are in place and reflect current best practice. Staff were observed to be in compliance with the infection control standards and is according to relevant legislation and current good practice. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. The ICC is responsible for monitoring and implementing the infection control programme. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC is a registered nurse and annual infection control education is provided. Training is conducted by the ICC and assessment questionnaires are used as when necessary. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets required legislative and current regulations. External contact resources included GP, laboratories and local district health boards. |
| 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 surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed respectively. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Staff actively work to minimise the use of restraint. All staff receive education regarding restraint minimisation and staff interviewed were clear regarding the difference between restraint and enabler use. The service currently has no residents using restraint or enablers. A restraint register was sighted |

# 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.

# 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.

End of the report.