# Graceful Home Limited

## Introduction

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

The audit has been conducted by HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Graceful Home Limited

**Premises audited:** Rose Lodge Rest Home

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

**Dates of audit:** Start date: 5 February 2016 End date: 5 February 2016

**Proposed changes to current services (if any):** Nil

**Total beds occupied across all premises included in the audit on the first day of the audit:** 10

# 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

Rose Lodge Rest Home can provide care for up to 14 residents requiring care at rest home level with 10 residents on the day of audit. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

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

The owner/manager is responsible for the overall management of the facility and is supported by the caregivers and a registered nurse. Service delivery is monitored.

The service has addressed improvements required at certification to the following: most human resource issues apart from registered nurse training and performance appraisals; documentation of daily resident checklists; strategies to manage behavioural concerns, the activities programme; most environmental issues apart from a window that requires repair.

Further improvements required at certification remain around documentation of the second in charge role, the quality and risk management programme, notification to an external authority, resident assessment and care planning and the medication management system.

## 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 interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident with this recorded in the resident file. Residents and family state that the environment is conducive to communication including identification of any issues.

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

Rose Lodge Rest Home has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed by an external consultant with six weekly resident and staff meetings.

There are human resource policies documented around recruitment, selection, orientation and staff training and development with improvements required at certification met around orientation, criminal vetting, definition of roles and reference checking. Improvements continue to remain to training for the registered nurse.

Documentation of daily checks of residents is completed.

Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

There is a documented quality and risk management system and policies are reviewed by an external consultant. Improvements required at certification around the quality and risk management programme remain including analysis of quality data, documentation of resolution of issues and reporting of an incident to an external authority when required.

## 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. |

There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Resident files reviewed indicate that the resident is reviewed by the general practitioner monthly to three monthly as required.

Planned activities are appropriate to the group setting with a diversional therapist now employed. The residents and family interviewed confirm satisfaction with the activities programme.

There is a medicine management system in place with improvements continuing to be required to staff training and to storage of medication and to photo identification.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. An improvement is required to dietary assessments.

## Safe and appropriate environment

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

All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks.

The improvements required at certification around repairs and maintenance have been addressed apart from one area.

## 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 minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There are no restraints or enablers in use in the facility.

## Infection prevention and control

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

Infection prevention and control policies and procedures are adequately documented. There is a designated infection control co-ordinator (registered nurse) who is responsible for ensuring monthly surveillance is completed.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 7 | 0 | 5 | 6 | 0 | 0 |
| **Criteria** | 0 | 29 | 0 | 6 | 8 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation’s complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes periods for responding to a complaint. Complaint’s forms are available in the facility.  A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint’s folder. Two complaints were tracked and the review indicates that all timeframes taken to inform the complainant and resolve the issues raised were met.  Residents and family members all state that they would feel comfortable complaining.  There have not been any complaints forwarded by the Health and Disability Commission or other external agencies since the last audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.  If the resident has an incident, accident, a change in health or a change in needs, then family are informed as confirmed in a review of accident/incident forms and in the resident files noting that few residents have family involved in their lives.  Files reviewed include documentation around family contact. Interviews with a family member confirm they are kept informed.  Interpreting services are available when required from the District Health Board. There are no residents requiring interpreting services at the time of the audit. All residents interviewed confirm that staff are approachable and communicate in a way that meets their needs.  An information pack is available in large print and staff interviewed advised that this could be read to residents.  Staff can describe communicating with residents who have difficulty with communication. Only three residents could be interviewed on the day of the audit and one family member. Other residents who were able to communicate or family who were engaged were not available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | The owner/manager provides operational and strategic leadership for Rose Lodge Rest Home. Rose Lodge Rest Home has a documented mission, values and goals. The facility was purchased in February 2014 and can provide care for up to 14 residents requiring rest home level care. The owner/manager has been a senior caregiver in a psycho – geriatric area for 15 years and owned a home care company for private clients. The owner/manager states that there is an external accountant completing the financial oversight of the business.  Organisational plans are documented in the business plan however the plan is not yet reviewed. |
| 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. | PA Low | In the absence of the director, the registered nurse is delegated as second in charge. The registered nurse has had two years’ experience in nursing and a year’s experience in providing rest home care. The owner/manager states that the registered nurse is aware of the role however, the registered nurse was on leave during the audit and was not able to confirm this. An improvement continues to be required to documentation of the role of second in charge. |
| 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. | PA Moderate | The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews with these reviewed last in 2013 and on an ongoing basis by an external consultant. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. The policy around wounds has been updated to include information provided by the Ministry of Health around pressure injuries.  Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Corrective action plans are documented however; there is a lack of evidence of resolution of issues. Quality improvement data can be analysed through meetings. All staff interviewed report that they are kept informed of quality improvements although not all aspects of the quality programme are tabled for discussion at each meeting. Improvements continue to be required to the analysis and discussion of data through the six weekly staff meeting and documentation of evidence of resolution of issues.  There are six weekly resident meetings for those who wish to attend.  The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which includes a documented hazard management programme and a hazard register for the service. Any hazards identified are signed off as addressed or risks are minimised or isolated. An organisational risk management plan is documented.  There is an annual satisfaction survey for residents and family with this last completed by residents in 2015. There are few residents or family able to respond to the satisfaction survey. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low | The owner/manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. The service is committed to providing an environment in which all staff were able, and encouraged, to recognise and report errors or mistakes and were supported through the open disclosure process. This was confirmed in interviews with staff and the registered nurse. There is an improvement required at certification around notification of a serious incident. The improvement required remains. Appropriate authorities have been informed of the change in the registered nurse.  Staff receive education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to document all untoward events.  Ten incident reports were selected for review. All incidents were graphed monthly, reviewed and signed off by the registered nurse. An improvement is required to ensure that evidence of essential notifications is maintained. |
| 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 Moderate | Human resource policy and processes are in place. Both registered nurses including the relief registered nurse hold current annual practising certificates. Current visiting practitioners’ practising certificates reviewed are current and include that of the general practitioner. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file for permanent staff however an improvement is required to a contract for the relief staff.  Reference checking for new staff now occurs as sighted on files reviewed. The previous improvement required at certification has been met. Criminal vetting is completed and the previous improvement required at certification has been met. Roles have been defined for staff and the previous improvement required at certification has been met.  Most staff files reviewed have a current performance appraisal on file. The previous improvement required at certification remains.  An orientation programme is available for staff. Staff files show completion of orientation and the previous improvement required at certification has been met. Staff are able to articulate the buddy system in place.  Training is identified on an annual training plan. Evidence of training is held for all staff, with folders of attendance records retained. The permanent registered nurse has attended training through the district health board with records maintained. Staff have had training around abuse and neglect in 2015 An improvement is required to training around pressure injuries particularly for the registered nurse and for the registered nurse to complete training around infection control. The registered nurse has completed training for InterRAI assessments. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There are nine staff including the owner/manager, registered nurse, a diversional therapist, two cooks and caregivers employed in the service.  The staffing policy is the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.  The rosters included a caregiver on each shift. The owner/manager is on site for at least five days a week and the registered nurse is contracted to provide 20 hours a week. A relieving registered nurse was continuing to provide cover on the day of the audit with the permanent nurse on leave. The owner/manager and the registered nurse are available on call.  Residents and the family member interviewed confirmed staffing is adequate to meet the residents’ need. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Entries to records are legible, dated and signed by the relevant caregiver, registered nurse or other staff member including designation. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts are in a separate folder with medication. This is appropriate to the service.  Daily care checklists document when cares have been completed and the previous improvement required at certification has been met. |
| 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 | Medication areas, including controlled drug storage areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. One resident self-administers medication on the day of the audit however a secure place to store medication was not available. There are no controlled drugs on site.  All staff authorised to administer medicines have competencies however some are out of date.  The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.  Medicine charts evidence legibility, as required (PRN) medication is identified for individual residents and correctly prescribed and three monthly medicine reviews are conducted. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given). Residents’ medication files evidence that discontinued medicines are signed and dated by the general practitioner.  Improvements are required to residents' photo identification and to standing orders.  The residents self-administering medicines do so according to policy with the general practitioner deeming the resident competent to be self-administering. |
| 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. | PA Low | The food service policies and procedures are appropriate to the service setting with a menu reviewed by a dietitian (refer 1.2.3). There are two cooks and both have completed food safety training.  The cook confirmed they are aware of the residents’ individual dietary needs with these documented on a register. The residents' dietary requirements are identified, documented and reviewed with the review held in the resident file. The file in the kitchen does not include the current dietary assessment. The kitchen staff state that they are informed if resident's dietary requirements change.  The residents' files demonstrate monthly monitoring of individual resident's weight (refer 1.3.6). In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.  The food temperatures are recorded daily with these within normal range. Fridge and freezer temperatures are taken (refer 1.2.3.6). All decanted food is dated and food is covered and off the floor. |
| 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 residents' care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents. Short-term care plans are documented for some short-term needs such as infections. When completed, there is evidence that some are linked to the long-term care plan.  The general practitioner documentation and records are current. In interviews, residents and family confirmed that the resident’s current care and treatments met their needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist could not be interviewed on the day of audit as they were on leave. The owner/manager confirms the activities programme meets the needs of the service group and the service has appropriate equipment.  A diversional therapist is employed for 35 hours a week and the previous improvement required at certification has been met. Completion of the diversional therapy training was sighted on file.  Regular exercises and outings are provided for residents and a number of residents are very active in the community and are able to access this themselves. Each resident has an activities assessment and plan specific to their interests and level of activities. Activities plans are reviewed however these should be reviewed at the same time as the care plans (refer 1.3.3). The caregivers described offering activities to residents in the absence of the diversional therapist. Activities include arts, crafts, intellectual activities and spiritual offerings. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Periods in relation to care planning evaluations are documented. The residents' long-term care plans are reviewed six monthly. There is evidence of resident, family and caregiver input in care plan evaluations.  The residents’ progress records are entered on each shift. When resident’s progress is different than expected, the registered nurse contacts the general practitioner as confirmed by the general practitioner interviewed. Short-term care plans are in some of the residents’ files, used when required (refer 1.3.6). The short-term care plans include short-term goals and detailed intervention when documented. The family are notified of any changes in resident's condition as confirmed by the family member interviewed.  Care plans are not always updated when changes occur. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date September 2016). There have been no building modifications since the last audit. The owner/manager completes maintenance with a planned approach to addressing issues. One maintenance issue remains from the previous certification audit while others have been addressed.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities.  Equipment relevant to care needs is available and staff confirm that there is always sufficient.  A test and tag programme is in place. Equipment is calibrated.  There are safe external areas for residents and family to meet/use and these include paths, seating and shade. |
| 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 permanent registered nurse is responsible for the surveillance programme for the service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis with the information documented in the infection log maintained by the registered nurse. Antibiotic use is documented.  There is evidence in staff meeting minutes of discussion around infections noting that there are few infections in the facility. Residents with infections have short-term care plans mostly completed to ensure effective management and monitoring of infections (refer 1.3.6). Interviews confirm information relating to infections is made available for staff during handover and at staff meetings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. There are no residents using enablers in the facility and there is no evidence of use of restraint. Staff confirm that that enablers and restraint are not used.  The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety as confirmed at staff and management interviews. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | The owner/manager is aware of the need to review the business plan. | The annual business plan is not reviewed. | Document and review the annual business plan.  180 days |
| Criterion 1.2.2.1  During a temporary absence a suitably qualified and/or experienced person performs the manager's role. | PA Low | The registered nurse is delegated as the second in charge if the owner/manager is absent. The relief registered nurse was on duty on the day of the audit and is not designated as the second in charge. | There is no documented job description or documentation of responsibilities to ensure that the registered nurse is aware of the key tasks and responsibilities of the second in charge role. The previous improvement required at certification remains. | Document the responsibilities of the second in charge role.  90 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Moderate | There is documented evidence of communication with staff and the owner/manager through six weekly staff meetings and through six weekly resident meetings. Staff meetings include some discussion of the quality programme. The staff meetings now table data around incidents, infections, restraint and other indicators with a process to record this introduced since the last certification audit. | Not all aspects of the quality and risk management programme are discussed and analysed through staff meetings. This would include discussion of pressure injuries, incidents and wounds. The previous improvement required at certification remains and the risk rating has been raised from low to moderate. | Provide evidence that all aspects of the quality and risk management programme is reviewed and analysed through the staff meeting.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | There is an established meeting schedule and data is tabled at the meetings. There is evidence in meeting minutes of discussion around some aspects of the data with some evidence of improvements made because of the discussions. The owner/manager and staff interviewed are able to describe how data would lead to improvements.  The internal audit schedule is implemented and the previous requirement identified at certification has been partially met.  Corrective action plans are documented including issues identified through the dietician review, fridge and freezer temperatures when these are not in range and internal audits. | Corrective actions are not always signed off as resolved. The previous improvement required at certification remains. | Ensure that corrective actions are signed off as resolved including those identified through the dietician review and the internal audit programme.  90 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | There has been an incident that resulted in serious harm prior to the previous certification audit. The owner/manager stated that the registered nurse had informed the District Health Board and the Ministry of Health however documentation was not found relating to this. | There is insufficient evidence that appropriate authorities are notified following a serious event. The previous improvement required at certification remains and the timeframe to send in the report has been shortened. | Maintain evidence that the appropriate authorities have been notified following an incident.  30 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | A registered nurse relieves for the registered nurse when on leave. The relief registered nurse provided a copy of the annual practicing certificate. | A contract for the relieving registered nurse is not documented. | Document a contract for the relieving registered nurse with evidence of other documentation required such as a copy of the annual practicing certification held on file.  30 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There is a training calendar and training has been completed in line with the schedule. Training around abuse and neglect has been provided to staff in 2015 and the previous improvement required at certification has been met.  The registered nurse did not have additional infection control training and has not completed training around pressure injuries.  There was an annual appraisal process documented in the policy manual with an associated template. The owner/manager is aware that staff are expected to have an annual performance appraisal and three of five files have a current performance appraisal on file.  There is a training calendar and training had been completed with attendance records kept. | The permanent registered nurse has not completed training around management and monitoring of pressure injuries in 2015 or additional training around infection control. The previous improvement required at certification remains.  Two of five staff files do not have a current performance appraisal on file. The previous improvement required at certification remains with the risk rating increased to moderate. | i) Ensure that the registered nurse completes training around management and monitoring of pressure injuries and additional training around infection control.  ii) Ensure that all staff have a current performance appraisal on file.  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 | Eight of the 10 medication files have a resident’s photo in place. Other forms of identification were used by the caregiver administering medication on the day of the audit. | i). Residents photos are not on two files and ones that are do not consistently record the date the photo was taken and confirmation of the true likeness of the resident.  ii) Standing orders are documented however these are not in line with current guidelines.  There is no secure storage for residents who self-administer medication. | i) Ensure that there is photo identification on all resident medication files and provide evidence that residents’ photos on the medication charts are dated and confirm true likeness of the resident.  ii) Review standing orders to ensure that they are in line with current guidelines.  Provide secure storage for residents who self administer medication.  90 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Two of five staff files include a current medication competency and one other was last reviewed in December 2015. | Two staff who administer medications do not have a current medication competency on file. | Ensure that staff have an annual medication competency on file. The previous improvement required at certification remains.  30 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | Dietary assessments are updated at least six monthly and held in the resident file. | The file in the kitchen does not include the current dietary assessment. | Ensure that the resident file in the kitchen includes the current dietary assessment.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Needs assessments were not sighted on files reviewed. The registered nurse completes assessments and care plans including review with residents and family whenever possible. | i) A needs assessment was not sighted on files reviewed. The previous improvement required at certification remains and the risk rating has remained as moderate however the needs assessment service should be contacted on the first working day after the audit.  ii) InterRAI assessments are not yet being completed.  iii) Two of the five files reviewed did not evidence a full holistic reassessment of the resident.  One new resident does not have a care plan documented within three weeks of admission.  Activity assessments and plans are on file but not reviewed at the same time as the care plan. | i) Ensure that there is a needs assessment for all residents completed prior to admission. The previous improvement required at certification remains. The needs assessor must be contacted immediately and a plan developed to address the issue on the first working day following the audit.  ii) InterRAI assessments are not yet being completed. The timeframe to address this is 90 days.  iii) Two of the five files reviewed did not evidence a full reassessment of the resident. The timeframe to address this is 90 days.  One new resident does not have a care plan documented within three weeks of admission. The timeframe to address this is 7 days.  Complete review of activity plans are at the same time as the review of the care plan. The timeframe to address this is 180 days  7 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 | Short-term care plans are documented for some short-term issues. | Some short term issues are not documented in short term care plans with those identified including weight loss for one resident. | Document short-term care plans when issues are identified and link to the long-term care plans.  30 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Long-term care plans are evaluated six monthly. Six short-term care plans are reviewed when documented and signed off as resolved. | Two resident files reviewed did not indicate that care plans were updated as changes occurred when different from cares documented. | Ensure that care plans are updated as changes occur.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | Maintenance is completed with issues addressed when these are identified. Areas identified at certification audit have been mostly addressed. The owner/manager states that the builder has already been booked to address a rotten window frame. | There is one area of rot in a bathroom window. The previous improvement required at certification remains. | Ensure that the bathroom window is safe and able to meet infection control standards.  90 days |

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

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

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

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

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End of the report.