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

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

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

The specifics of this audit included:

**Legal entity:** Discover Oasis Limited

**Premises audited:** Concord House Rest Home

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

**Dates of audit:** Start date: 22 April 2016 End date: 22 April 2016

**Proposed changes to current services (if any):**  Change of ownership

**Total beds occupied across all premises included in the audit on the first day of the audit:** 7

# 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

Concord House rest home is privately owned and operated. The service is certified to provide rest home level of care for up to 15 residents. On the day of the audit there were seven residents.

This provisional audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with family, management, staff and the nurse practitioner.

The director is the manager and is supported by an assistant manager. Both are responsible for the operation of the home. The director/manager has had 18 years working in aged care. They are supported by a part-time registered nurse and long serving staff.

This audit identified improvements required around internal audits, mandatory training, clinical notes, general practitioner documentation, care plans, interventions, electrical checks, infection control programme and external infection control training

The prospective owner/directors report the current policies, systems and staff will remain in place following the purchase. The current owner will continue to provide support to the new owner for three months following purchase. Additional support will be provided if required after this.

## Consumer rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Informed consent is sought from residents and where appropriate, their legal representatives. Care planning accommodates individual choices of residents and/or their family/whānau. Residents and family interviewed spoke positively about care provided at Concord House. Complaints procedures and complaints forms are readily available to residents and relatives.

## Organisational management

Concord House is implementing a quality and risk management system that supports the provision of clinical care. There is a current business and quality plan in place. An experienced manager/owner and assistant manager/shareholder are responsible for the daily operations of the home. Quality data is collated for infections, accident/incidents, concerns/complaints and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The education programme includes external education for caregivers, the manager and RN. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

Resident’s needs are assessed prior to entry. An information pack is available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed using interRAI. Short-term care plans are in use for health changes.

There is an individual and group activities programme running. The group activities programme is overseen by a diversional therapist and implemented by caregivers.

There is an established system of medicines management in place. The caregivers and the registered nurse have completed medication competencies and education annually.

Food services policies and procedures are appropriate to the service setting. Resident's individual dietary needs are identified, documented and reviewed on a regular basis.

Residents and family members interviewed were complimentary about service delivery.

There are no changes planned to the medicines management system or the food service with the change of ownership.

## Safe and appropriate environment

The service has implemented policies and procedures for fire, civil defence and other emergencies. The building holds a current warrant of fitness. Rooms were individualised. External areas were safe and accessible. The facility has a van available for transportation of residents. There is a main lounge and separate dining room. There were adequate communal toilets and showers. Fixtures, fittings and flooring are appropriate for rest home level care. Residents were satisfied with the cleaning and laundry services. Chemicals were stored securely. The temperature of the facility was comfortable and constant.

## Restraint minimisation and safe practice

The residents are of the level where enablers and restraints are not considered necessary. On the day of audit there were no residents using enablers or restraints. There are policies and procedures available should restraint become necessary and a procedure for managing residents who may exhibit challenging behaviours.

## Infection prevention and control

The infection prevention and control programme is suitable for the facility. The programme is led by the registered nurse with support from staff and external agencies. The programme is based upon defined policies and procedures. General practitioners are actively involved in the management of residents with suspected infections. Education is provided to staff by the registered nurse on an ongoing basis. Infections are monitored and practice is reviewed every month. Trends are able to be identified. There have been no recent outbreaks of infection in the rest home.

## 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 | 37 | 0 | 5 | 3 | 0 | 0 |
| **Criteria** | 0 | 84 | 0 | 6 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). The Code of Rights is clearly displayed at the main entrance. Three residents and two relatives interviewed confirmed that information has been provided around the Code of Rights. There is a resident rights policy in place. Discussion with two caregivers identified that they were aware of the Code of Rights and could describe the key principles. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has policies and procedures relating to informed consent, resuscitation and advanced directives. All five resident files reviewed included signed agreements including consents and resuscitation instructions. Staff were aware of advanced directives. Discussions with residents and families identified that the service actively involves them in decision making. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Caregivers interviewed are aware of the resident’s right to advocacy services and how to access the information. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and family and friends visit the home frequently. Residents and relatives verified that they have been supported and encouraged to remain involved in their community groups. The service has a van and outings into the community are offered. Community groups visit the home as part of the activities programme. The community newsletter was available in the main entrance. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the privacy officer (manager) using a complaints’ register. There have been no complaints made in 2015 or 2016 (year to date). Residents and family members interviewed advised that they were aware of the complaints procedure and the manager is very approachable and always available should they have any concerns to discuss. There is a suggestions, compliments and complaints letter box in the main entrance. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information folder for potential residents and their families that include information about the Code of Rights. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. Residents and family members interviewed state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. Staff sign a confidentiality clause on employment. Residents and family state staff are very respectful and caring. Staff encourage residents to be independent where able. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Māori health plan and cultural awareness policy. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. On the day of the audit there were no residents that identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Residents are supported to maintain their spiritual and cultural needs. Families interviewed confirm staff provides culturally acceptable care for the residents at the home. The manager attended a cultural workshop in June 2014 (1.2.7.5). |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of a service Code of Conduct. Professional boundaries are defined in job descriptions. Staff are observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with caregivers could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The manager/owner is committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. Residents and families spoke positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant to provide a good level of assurance that it is adhering to relevant standards. Staff have a sound understanding of principles of aged care and state that they feel supported by management. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promote an open door policy. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Annual resident/relative surveys (in English and Chinese) are completed annually on all areas of the service. There were seven out of seven returns and 100% response was “always” and no concerns. Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. Information is provided in formats suitable for the resident and their family. The residents are predominantly of Chinese culture. Staff interviewed could describe how they communicate with residents to understand and meet their needs. The complaints/compliments form is in English and Chinese. Resident meetings are held monthly and open to families. A staff interpreter translates the meeting in English, Cantonese and mandarin. On the day of audit an interpreter on staff was available for the residents/families. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Concord House provides rest home level of care for up to 15 residents. On the day of audit there were seven permanent residents including one younger person under 65 years and one resident under ACC funding.  Concord House has been privately owned by one director (manager) for four years. The manager is actively involved in the service and lives on-site. The assistant manager (shareholder) is one of the cooks. The management team is supported by a part-time RN who was appointed December 2014.  The business plan includes the service mission, philosophy of care, values and vision. The business and strategic plan 2015 to 2017 was reviewed in September 2015. An organisational chart identifies responsibilities and the reporting structure. The quality plan was also reviewed with staff involvement as evidenced in staff/quality review meeting. Goals for the service focus on providing a safe home-like environment. Environmental improvements are the upgrade of a large shower room including new flooring.  The manager has attended at least eight hours of education relating to managing a rest home including interRAI managers training, medication competency, attending DHB provider meetings and ARCC cluster group meetings. The manager attends aged care clinical support study days at the DHB.  Interview with one of the new owners advises the tentative sale will take place as soon as the change of ownership has been approved by HealthCERT. There will be two directors/owners (tenants). One director/owner will be the manager of the facility and live on-site in one of the downstairs flats. The other director will continue in her employment as a social worker within the Asian mental health services at two Auckland DBHs.  The prospective owner/manager is non-clinical and has graduated with a master’s degree in architecture and graphics. She then worked in real estate which has given her experience and skills in customer service, provision of services and building of relationships and had knowledge around building regulations and requirements. The prospective manager was a volunteer at a rest home in 2007 working alongside the activities coordinator and is familiar with the rest home environment and residents rights. She will be responsible for the non-clinical areas of staff, finances and budget, maintenance, health and safety compliance, investigations, complaints management and coordinate activities.  The prospective owner/manager has been living on-site since 23 March 2016 and receiving mentorship from the current manager who also lives in a flat on-site. There is a detailed transition plan for the first six weeks which includes introductions to staff, residents, families and a full orientation of the service, contracts, utilities and a fire drill. Admission procedures, documentation, staff meeting, supplies and meeting contractors and allied health professionals has been completed. The prospective owner/manager has attended a DHB cluster meeting and a caregiver study day at the DHB with the current owner/manager. The prospective owner/manager is registered for first aid training on the 19 May 2016. On-site education has been scheduled for Code of Rights, open disclosure, informed consent and complaints management with the health and disability advocate. All staff including the prospective owner/manager will attend. The transition plan covers ongoing support from the six week transition period. The current owner/manager will continue to live on-site for the next three months and be available/on call to support the new owner/managers.  The new owners/directors have a business plan covering objectives for the first year. Environmental improvements include the following maintenance plan as finances permit: a) interior painting, b) new furniture in communal areas of the home, c) refurbishment of resident bedrooms, d) landscaping of the garden area, e) upgrade of technology over the next year to a cloud based system for the storage of all data including policies and procedures, f) increase marketing of the home and improve the occupancy, and g) embrace the unique multicultural diversity among residents and staff focusing on activities that enhance relationships and communication, and h) involve the wider community and outreach programmes in activities such as volunteers, pet therapy and a hairdresser. |
| 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 | During a temporary absence of the owner /manager, the part-time RN would cover the facility manager’s role. The current manager/owner and assistant manager/shareholder (and cook) live on-site and have not been absent over the four year period for any length of time. Interview with the new owner/manager confirms the current manager or second director/owner will be available to provide non-clinical cover.  A review of the documentation, policies and procedures and discussion with staff identified that the service’s operational management strategies includes culturally appropriate care to minimise risk of unwanted events and enhance quality. |
| 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 Low | Concord House is implementing a quality and risk management system which is reviewed annually. Policies and procedures are in place for managing business and clinical risk. Policies and procedures have been developed and updated/reviewed (2015) by an external aged care consultant. The policies and procedures are readily accessible for staff. Staff interviewed confirm they are notified when policies/procedures have been updated/reviewed.  The new owner/manager stated the aged care consultant would continue to be contracted under new ownership.  There are monthly staff/quality review meetings held for all staff. Meeting minutes evidence discussion around accidents/incidents, infection control, medications, concerns/complaints, health and safety, hazard management and document control. Accident/incident and infection control data and graphs are available to staff. Staff are required to sign meeting minutes when read. Staff have been informed of the change of ownership and met the new owner/manager at the last meeting held March 2016.  The quality risk system does not include an annual internal audit programme. Annual resident/relative surveys were completed September 2015.  There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for overall health and safety. Health and safety objectives are included in the business/quality plan and reviewed annually. Hazard identification/building maintenance forms are readily available. Forms sighted have been addressed in a timely manner including carpet repairs and leaking washing machine (replaced). There is a current hazard register in place. Health and safety and hazards are discussed at staff meetings and documented in the meeting minutes. Staff interviewed (two caregivers, one RN, one cook and one cleaner) were aware of the hazard identification process.  Falls prevention strategies were in place that includes the analysis of falls/incidents, intentional rounding and the identification of interventions on a case-by-case basis to minimise future risk. |
| 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 | Seven accident/incident forms (three December 2015, two February and one March 2016) were reviewed. There has been RN notification and clinical assessment completed within a timely manner. All recorded accidents/incidents documented in the resident progress notes identified the family had been notified.  The service collects incident and accident data and reports aggregated figures monthly to the staff/quality review meeting. Staff confirmed incident and accident data is discussed at the staff meeting as documented in meeting minutes sighted.  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.  Discussion with the manager identified an awareness of reporting requirements to relevant personnel for essential notifications. There has been no cause for DHB or HealthCERT reports. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resources policies to support recruitment practices. Five staff files reviewed contained all relevant employment documentation including police checks. Performance appraisals were current for staff employed over one year. Current practising certificates were sighted for the RN and allied health professionals.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.  Care staff rotate to attend the study days for caregivers held at the DHB. The programme includes some mandatory training. Additional training is held on-site, however not all mandatory training has been offered within the last two years. There is external training available to the manager and RN. Clinical staff completes competencies relevant to their role. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager is on-site during the day Monday to Friday and lives on-site. A part-time RN is employed for 12 hours over three days of the week and is available on call. The GP and St Johns ambulance are also available to complete clinical assessments as required. There is a dedicated cook seven days a week and a cleaner four hours a day Monday to Friday. The caregivers are involved in activities for the residents.  The new owner/manager confirmed there will be no changes to the current care and support staff. The assistant manager/cook will be employed as the cook under the new owner/manager. The new owner/manager will be available 24-hours for facility/staffing matters. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked file. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Entries in resident clinical records do not identify the writer and are not dated. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry criteria are documented in the welcome pack. All new admissions are required to have a needs assessment whether paying privately or funded by a government agency. The welcome pack is provided to all prospective residents and their families before admission outlining services available. The pack includes information on their rights, the Code, complaints management, advocacy and the admission agreement. Family members and residents interviewed stated that they had received sufficient information prior to and on entry to the service. The current admission agreement aligns with the ARCC requirements and includes exclusions from the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has transfer and discharge policies and procedures in place. The procedures include the use of the DHB developed (i.e. ‘yellow envelope’) system to manage information during transfer and discharges. |
| 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 | No changes are planned by the prospective owner to the existing medicines management system.  All medicines are prescribed by the in-house GPs (confirmed in review of all seven of seven residents’ medicine charts). All medication charts are pharmacy-generated, recorded correctly and signed correctly by the resident’s general practitioner. Allergy status is recorded. Medicines are administered as prescribed by caregivers and signed for correctly. A medicine round was not witnessed as no residents required medicines at lunchtime. All medicines are stored securely when not in use. The facility uses the blister pack medication management system. Medicines are typically delivered every four weeks usually unless additional medicines are needed. Medicines are reconciled on delivery by the RN prior to use. All medication charts are legible and reviewed three monthly. There are appropriate medication policies and procedures in place including policy for residents who self-administer their medicines. No subsidised residents were self-administering medicines. Standing orders were not in use.  Competency is assessed annually when due. The RN was assessed as competent by another medication competent RN. Education for caregivers on medicine management is completed annually. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | No changes are proposed by the prospective owners to the food service.  Currently the facility employs two cooks. The main cook is the husband of the current owner and shareholder. He will continue to be employed by the prospective owners. The weekend cook will continue to work for the prospective owners. The cooks work from 9am to 1pm and 3pm to 6pm. Both cooks have completed food safety education. The majority of food is prepared and cooked on-site. The cooks prepare meals to meet both European and Asian preferences reflecting the resident cultural mix. Daily monitoring records are maintained of food temperatures and refrigeration and freezer temperatures. Food is served directly to residents in the adjourning dining room. Food services policies and procedures are appropriate to the service setting. There are four weekly menus in place that have been approved by a dietitian. A dietitian has conducted a menu audit on 19 April 2016, has reviewed and changed the menu and has made some recommendations which relate to documentation.  Residents’ dietary profiles are kept in the kitchen. Resident preferences are accommodated and dislikes accommodated. Special equipment is available as needed. Additional fluids and food are available for residents when the kitchen is closed. There are no residents requiring special diets at present. Residents and family members interviewed were complimentary of the food service 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 service has a process for declining entry should this be necessary. Each person seeking entry is required to be assessed and if not suitable for admission then the manager will advise of alternative options This includes informing persons and referrers (as applicable) of the reasons why the service has been declined. Management reported that they have not had to decline entry to prospective rest home residents provided the facility has a vacancy. The reason for declining service entry to residents would be recorded and communicated to the resident/family/whānau and alternative options suggested if appropriate. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An initial nursing assessment and initial care plan is completed within 24 hours of admission by the registered nurse. Personal needs, outcomes and goals of residents are identified. There are a range of assessment tools completed on admission which include a general assessment, a pain assessment, a continence assessment, a falls risk assessment and a pressure injury assessment. The assessment tools link to the individual care plans. Cultural needs (including language) are recorded in the interRAI assessment notes and are reflected in the care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The interRAI assessment, assessment summary (which includes triggered clinical assessment protocols (CAPs), outcome scores and the needs identified by the registered nurse’s clinical judgement, informs the development of the care plan. All five care plans reviewed referenced the identified CAPs. Comprehensive long-term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Residents and family members interviewed stated they are involved in the care planning process. All care plans reviewed recorded sufficient detail to guide care staff. Short-term care plans were evidenced in use for short term needs such as infections or skin tears. |
| 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 | Service delivery is guided by the resident’s plan of care. When a resident’s health status changes the RN or manager initiates a GP or nurse specialist consultation. Short-term care plans are used for residents with short term needs (for example skin tears, infections, short term pain management). A gerontology nurse specialist from the DHB is available to provide clinical advice and support. Other specialist involvement including the mental health service are available, however the service had not been accessed as recommended in the file notes of one resident. Family interviewed stated the services provided met their expectations and the needs of their relative. Family also confirmed they are notified promptly of any health changes to their relative.  Caregivers and the registered nurse interviewed stated that they have sufficient equipment to provide care as instructed in the care plans. Clinical supplies are available including adequate wound care products and continence products. There were no wounds or pressure injuries on the day of audit. Wound assessments are available for use as required.  Chair scales are used to weigh residents monthly or more frequently if necessary. Weights have not been recorded in individual clinical records. Monitoring forms are available as required such as observations and behavioural monitoring. A shortfall was identified around behavioural monitoring. |
| 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 | A diversional therapist is employed to provide a service for one hour fortnightly. The registered nurse conducts the social assessment and reviews the resident’s individual activities programme as part of the interRAI evaluation/reassessment process. All residents have an individual social activities plan developed shortly after admission. They can choose to participate in the group programme or they are encouraged to choose an activity from their individual programme. There is flexibility in the programme for offsite group activities and van rides. The programme includes occasional entertainers. The group activities implemented programme is run by the caregivers. Caregivers supervise and escort residents who wish to go for daily walks or van rides. The business owns a seven seater van, which can accommodate five residents, a driver and a staff member. Group activities are held in the lounge. Residents were observed participating in the programme. One resident was visited by a student volunteer (Duke of Edinburgh) on the day of audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents are reassessed using the interRAI process at least six monthly. The RN reassesses residents if there has been a significant change in their health status. The GPs review residents three monthly or when requested for health changes. Short-term care plans are in use and evaluated regularly. Care plans are goal orientated and evaluated at six monthly intervals and document progress against the resident goals. The review dates are recorded in the interRAI documentation. |
| 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 | The service facilitates access to medical and non-medical services. Residents, family and the resident’s GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the registered nurse. Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemical product use and safety data sheets are available. Chemicals are stored safely. Gloves, aprons and goggles are available for staff. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. The chemical provider has completed chemical safety training with the staff October 2015. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | The service displays a current building warrant of fitness which expires on 22 July 2016. The building is two-storey with all resident areas upstairs and flats and laundry service/storage areas downstairs.  There is a reactive maintenance system in place. Hot water temperatures checks are monitored in resident bathroom/shower areas monthly. Records of temperatures are below 45 degrees Celsius. Medical equipment as applicable has been calibrated. Not all electrical equipment has been serviced regularly.  Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access to outdoor areas and decks. The external area provides seating and shade. Interviews with staff confirmed there was adequate equipment and supplies to provide safe and timely care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of communal toilets and showers. The toilets and showers are identifiable and include vacant/in-use signs. One shower room has been upgraded with acceptable materials to support good hygiene and infection control practices. Other toilet/shower areas are satisfactory. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. |
| 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 | There are thirteen single bedrooms and one double bedroom. Bedrooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre safely around the room with the use of mobility aids. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Residents are encouraged to personalise their bedrooms. The bedroom furnishings were appropriate for the resident group. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There was one main lounge and a dining room located close to the kitchen. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed report they can move freely around the facility and staff assist them if required. Activities take place in the lounge. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Personal clothing and linen are laundered on-site by the care/cleaning staff. The laundry is located downstairs with an external window and close to an exit door. The chemical provider monitors the effectiveness of laundry and cleaning processes. Residents and relatives expressed satisfaction with cleaning and laundry services. There is a dedicated cleaner employed for four hours a day Monday-Friday. The cleaning trolley is stored safely when not in use. Colour coded equipment is used for designated areas. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. Civil defence supplies include adequate stored water and food for three days. There is a barbeque and spare gas bottles. Staff receives orientation to emergency situations and location of supplies. In the event of a power failure there is emergency power supply for emergency lighting and call bells. The facility has a telephone landline that operates independent of a power source.  There is an approved fire evacuation plan dated 21 October 2005. Fire drills have been conducted six monthly last in March 2016. There is a first aider on duty at all times. Resident’s rooms, communal bathrooms and living areas all have call bells. The call bells ring to a main centralised panel.  Security policies and procedures are documented and implemented by staff. There is doorbell access and external lighting. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated (central heating) and ventilated with doors that open out onto the decks. Residents and family interviewed state the environment is comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low | The responsibility for infection prevention and control is held by a registered nurse with a current practising certificate. There are clear lines of accountability for infection prevention and control matters within the facility. There is a documented infection control programme that was issued on 1 January 2015, which has not been reviewed annually.  Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious where possible. Visitors who are unwell are asked not to visit. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control (IPC) team consists of the RN, the caregivers, the main cook and the cleaner. The team have access to GPs and staff from the DHB infection prevention and control team if needed. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are a range of written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. These policies were developed by an external contractor. Policies and procedures are reviewed by the IPC team. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | PA Low | Education on infection prevention and control is provided annually to staff and residents by the RN. Resident education occurs as applicable. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms and short-term care plans are completed for all infections. Infections are included on a monthly register and a monthly report and graphs are completed by the infection control coordinator and administrator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the management and staff meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP/NP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks.  There are documented policies and procedures in place to cover ongoing surveillance and the management of outbreaks. Any resident who is suspected of having an infection is reviewed by the registered nurse and their general practitioner. Specimens are taken as appropriate and a record of results is maintained in the resident’s clinical record. A record of all suspected and actual infections is maintained. This information is collated, analysed and reported at the monthly staff/quality review meeting. Trends can then be identified and further preventive action taken if required. Infection control data and graphs are available to staff. The rest home has a low infection rate. Typically infections are limited to urinary or chest infections. There have been no outbreaks of infections since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The registered nurse oversees the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service currently has no residents using enablers or restraints. Staff receives education around challenging behaviour. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | The quality risk management plan includes the implementation of an internal audit programme. Only three audits (two for 2015 and one for 2016) have been completed. Corrective actions were raised, implemented, signed off and discussed at the staff/quality review meeting. | There is no internal auditing programme in place to identify areas for improvement and monitor compliance against the required standards. | Ensure an internal audit programme is implemented and completed as scheduled.  60 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 Low | External education is available to caregivers, RN and manager through study days held at the DHB. The service accesses external speakers to provide education on-site. Not all mandatory training has been completed within the last two years. | Staff have not attended complaints management, open disclosure, Code of Rights, informed consent or cultural training within the last two years. The health and disability advocate has been scheduled to provide the training on 20 June 2016. | Ensure staff attends mandatory training every two years.  60 days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | Resident information is recorded in individual clinical records each shift by caregivers. Caregivers had not signed and dated clinical records in resident files reviewed. Records are integrated. They are stored in a locked filing cabinet when not in use. | Caregivers had not signed and dated clinical records in resident files reviewed. | Ensure resident clinical records are dated and identifies the writer.  90 days |
| Criterion 1.3.3.1  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. | PA Moderate | A registered nurse is employed to provide clinical oversight for the care of residents. Only one care plan of the five reviewed was signed as being developed by the registered nurse. Three care plans were signed by the manager (non-clinical). One care plan had no signature. | Three of five care plans were not signed by the registered nurse and one care plan was not signed at all. | Ensure all care plans are developed and signed by the registered nurse.  30 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 Low | Residents are reviewed at least three monthly or earlier by their general practitioner. General practitioners were not documenting how often to review the resident. | General practitioners were not documenting whether the resident was medically stable and to be reviewed three monthly in all five clinical records reviewed. | Ensure the GP documents if the resident is stable or not and the timeframe for review.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Services are provided which are consistent with each resident’s assessed needs. Short-term care plans are developed for residents with short term needs to guide caregivers in safe delivery of care. Residents are weighed monthly and their weights are recorded in a weight book and not in the clinical record. One resident (link tracer 1.3.3) required an urgent review due to deteriorating mental wellbeing. Challenging behaviours had not been recorded on the behavioural monitoring form. The GP was notified on the day of audit and an appointment scheduled for review. | (i) Five of five clinical records did not contain a recording of the monthly weight of each resident; (ii) one resident with a change in mental health wellbeing had not been referred to the GP for review as recommended in file notes by mental health services. The same resident did not have challenging behaviour incidents (as per the progress notes) recorded on the behavioural monitoring form. | (i) Ensure the monthly weight of each resident is recorded in the integrated clinical record; (ii) Ensure medical reviews occur within a timely manner for changes in health status. Ensure all challenging behaviours are documented on the behavioural monitoring form.  60 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Moderate | All electrical equipment upstairs including kitchen appliances have had an annual electrical warrant of fitness dated March 2016. One washing machine has been purchased within the last year. Other laundry equipment has not had an annual electrical warrant of fitness. | The second washing machine and dryer in the downstairs laundry have not had an electrical warrant of fitness since 2013. | Ensure all electrical equipment has a current electrical warrant of fitness.  60 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | There is a documented infection control programme that was issued on 1 January 2015. | The infection prevention and control programme is overdue for its annual review. | Ensure the infection prevention and control programme is reviewed annually.  60 days |
| Criterion 3.4.1  Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. | PA Low | Infection prevention and control education is provided to staff and residents by the RN. The RN’s employment record was reviewed and did not contain any evidence of external education on infection, prevention and control within the last year. | No evidence was sighted that the RN had maintained knowledge of current practice in infection, prevention and control. | Ensure the RN who is the infection prevention and control coordinator maintains knowledge of current practice in infection prevention and control.  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.