# TerraNova Homes & Care Limited - Riverleigh Residential Care

## Introduction

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

The audit has been conducted by The DAA Group 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:** TerraNova Homes & Care Limited

**Premises audited:** Riverleigh Residential Care

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 11 May 2016 End date: 12 May 2016

**Proposed changes to current services (if any):** The provider has made application to the Ministry of Health to extend the scope of services provided to include services for residents aged under 65 years with a physical disability. This audit included a review of the provider’s level of preparedness to provide this new service.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 55

# 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

Riverleigh Residential Care provides residential care for up to 64 residents who require rest home and hospital care and for residents under the age of 65 with a physical disability. The facility is operated by TerraNova Homes & Care Limited.

This certification audit was conducted against the Health and Disability Service Standards and the service’s contract with the District Health Board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, staff, a general practitioner and a nurse practitioner.

The service meets the requirements to provide services for younger residents with a physical disability.

There are no areas requiring improvement.

## 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. |

Services are provided that respect the personal privacy, independence, individual needs and dignity of residents. Staff receive regular training on residents’ rights and how to implement these. During the audit visit staff were noted to be interacting with residents in a respectful and calm manner.

Well-established processes are in place to promote open communication, and residents and their families confirmed these were effective.

Policies have been developed to ensure residents are free from discrimination or abuse/neglect, with these policies well understood by staff.

The service has strong linkages with a range of specialist health care providers, and these contribute to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints. A complaints register is maintained.

## Organisational management

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| --- | --- | --- |
| 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. |  | Standards applicable to this service fully attained. |

TerraNova Homes & Care Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Riverleigh Residential Care and documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the service, including regular reporting by the facility manager to TerraNova head office.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical coordinator/registered nurse. The clinical coordinator is responsible for oversight of the clinical service in the facility.

There is an internal audit programme. Risks are identified. An electronic reporting system is used to monitor and analyse data. Adverse events are documented on accident/incident forms. Corrective action plans are being developed, implemented, monitored and signed off. Various meetings are held and there is reporting of clinical indicators, quality and risk issues and discussion of any trends. Graphs of clinical indicators, including benchmarking are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management and human resource processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and attendance sheets are held on file. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and clinical coordinator are rostered on call after hours. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

Resident information is current, accurately recorded and maintained in a secure and confidential manner.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Registered nurses are on duty 24 hours each day to guide service provision. Either the facility manager or clinical coordinator, both experienced registered nurses, are available on call after hours. Residents’ progress notes are updated at least daily, and there are well-developed processes in place to guide continuity of care. The assessment of residents’ needs, care planning, and evaluation of resident progress towards identified goals are completed in a comprehensive and timely manner, based on integration of a variety of clinical information and the input of residents and families.

A full time activities coordinator, supported by a part-time activities assistant, are responsible for the activities programme. The activity needs and preferences of residents is diverse and programmes are in place and are also being developed to accommodate these. Although the service does not have its own mobility van residents have access to regular outings and are encouraged and supported to attend a variety of community activities.

Medications are prescribed in accordance with legislative and safe practice requirements. The management of medications is safe and appropriate.

All aspects of food services are well managed. A qualified chef leads the kitchen staff, all of whom have completed food safety qualifications. The kitchen was well organised and clean. The individual food preferences and dietary needs of residents are respected and catered for. There are two separate dining areas for residents.

## Safe and appropriate environment

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

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

There is single and double accommodation and some bedrooms with ensuites. Residents' rooms have adequate personal space provided. A number of lounges, dining areas and alcoves are available. External areas are available for sitting and shading is provided.

There is an appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed off site. Cleaning and laundry systems are monitored to evaluate the effectiveness of these services.

## 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. |

The service has clear policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There were no residents using restraint during the audit. Staff education and competency occurs at least annually. The restraint steering committee undertakes regular quality reviews to ensure compliance with policies and to consider all aspects of restraint and enabler use. The restraint/enabler register is current.

## 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 is led by an experienced and appropriately trained infection control coordinator. Staff have access to a range of personal protective equipment and receive regular training on infection-related matters.

Infection surveillance is systematic, and processes are in place to ensure that surveillance results are reported, analysed, benchmarked and action taken as required.

## 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **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 orientation of all new staff includes education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code), and education is then provided on the Code on an annual basis. This was confirmed in staff education records and in interviews with staff. During staff interviews there was evidence of staff having a good understanding of the Code and how this is implemented into their everyday practice. |
| 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 | A policy on informed consent is in place to guide service providers in relation to informed consent. At the time of admission, residents or their EPOA sign a consent form related to the collection of information, taking and use of photographs, general medical treatment, students, outings and flu vaccinations. Consent is then reviewed on an annual basis (as sighted in the clinical files reviewed) and on an as-required basis, such as if specialist medical treatment is required.  All but one of the resident’s records reviewed contained a completed resuscitation authorisation form, which included evidence of resident/family consultation, and medical authorisation. This form is reviewed annually and if a resident’s conditions changes. The resident who did not have a completed form is still making a decision about their resuscitation status, which has been respected by the service. There were currently no residents with advance directives, but the clinical coordinator advised that these would be respected.  During interview residents confirmed they were routinely offered the opportunity to make informed choices and that their consent was obtained and respected. Family members also confirmed their involvement in consent process when appropriate, and of being kept informed about what was happening with the resident. They were also consulted in situations such as when consideration was being given to transferring the resident to a public hospital. The admission documentation completed by each new resident and/or their family member identified inclusions and exclusions in service. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | New residents and their families are given a comprehensive information package which includes a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure. Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this. Information on the Advocacy Service is also readily accessible around the facility.  The staff orientation programme includes information on the Advocacy Service, which also features in the service’s ongoing education programme for staff. Education on the Advocacy Service was held earlier this year, as confirmed in staff training records.  On interview, staff demonstrated their understanding of the Advocacy Service, and how this service could be contacted. |
| 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 facility has unrestricted visiting hours and encourages visits from residents’ family and friends. All family members interviewed stated they felt welcome when they visited, and comfortable in their dealings with staff.  Residents who are well enough are encouraged to independently engage with the community, such as visiting family/friends, shopping trips and going to the movies. The activities coordinator advised that residents are also supported to participate in community events, with regular trips out. Children from a nearby centre visit the facility twice a month, with residents enjoying being able to read to and interact with the children. Visiting entertainers, and church services are also part of the activities programme.  Residents are also supported to access health care services outside of the facility, such as visits to the dentist, or doctor. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The facility manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There is evidence that complaints are managed appropriately.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Review of staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via staff meetings.  One complaint has been received since the last audit, by the Health and Disability Commissioner (HDC), concerning the care of a resident. Documentation indicated the HDC has received requested documentation from the facility and will advise when the investigation into this complaint is made. The facility manager advised there was another complaint made to the HDC, however this complaint was withdrawn. There have been no investigations by the Ministry of Health, the DHB, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | As part of the admission process new residents and their family are provided with a copy of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service). This is discussed with them during the admission process by a registered nurse. Further discussions and explanations are provided as required by the individual resident and/or their family. Copies of the Code, and the information on the Advocacy Service, are also displayed around the facility, and there is a copy in each resident’s room.  All residents and family members interviewed confirmed their understanding of residents’ rights and that information had been provided on the Code and the Advocacy Service. Residents or family members also stated that if they did have any questions or concerns they would feel comfortable discussing these with either any registered nurse, their case manager or senior facility staff. |
| 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 | All residents have a private room, or share a room with their spouse. There was evidence of residents being encouraged to personalise these rooms. Resident’s privacy was maintained during personal cares. Staff interactions with residents were observed to be respectful and pleasant, and included the use of the resident’s’ preferred name. Residents were encouraged to maintain their independence. This was particularly evident for those residents who were able to independently control their engagement and participation in a range of community activities, such as arranging their own visits to the doctor.  A review of residents’ records confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Each plan included detailed documentation related to the resident’s abilities, and strategies to maximise these. Plans were developed in partnership with the resident and/or their family. Residents and families stated on interview that they were treated respectfully and their individual needs were meet.  The privacy of residents’ information was maintained. Clinical files were kept in locked cabinets, electronic information was password protected, archived records were stored securely, and staff handovers were undertaken in a private area.  Staff demonstrated a good understanding of the service’s policy on abuse and neglect. They provided examples of what could constitute abuse and neglect and the actions they would take if they suspected this. Abuse and neglect education is part of the orientation process for staff, and is then provided on an annual basis, as confirmed in staff and training records. Appropriate processes are in place to ensure that police and referee checks are completed when new staff are employed. |
| 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 | The service has well-developed policies, protocols and other resources in place to ensure appropriate services are provided to residents who identify as Maori. Cultural beliefs and related requirements are integrated throughout each resident’s care plan. The clinical coordinator provided details of organisations and individuals who could be contacted if additional cultural support was required for any resident. The clinical coordinator also advised that room blessings are undertaken by a local minister after the death of a resident, and that if an additional Maori blessing of the room was required this could be arranged. There are currently two residents and one staff member who identify as Maori. |
| 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 personal values, beliefs and cultural requirements were comprehensively documented in all care plans reviewed, and included a range of strategies to ensure these were met. Evidence was sighted of resident/family involvement in the development of these plans. All residents and family members interviewed advised they had been consulted about individual values, beliefs and cultural requirements at the time of admission and as part of the care plan review process. They also confirmed that these values and beliefs were respected. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation. Two health professionals (a doctor and nurse practitioner) who are regularly on-site also confirmed their satisfaction with the services provided to residents, and their confidence that residents are free from any form of discrimination, abuse or exploitation.  Staff receive education related to discrimination and exploitation as part of the orientation process, with ongoing education offered annually, as confirmed in staff interviews and training records. Staff were able to give examples of what would constitute inappropriate behaviour, and the actions they should take if they suspected this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has a range of comprehensive and current clinical policies available to guide care delivery. Evidence was sighted in residents’ records of regular input from health providers such as the hospice, diabetes nurse specialist, wound care specialist, community dieticians, services for older people and mental health services. The clinical coordinator advised that these specialist providers were available as resources if additional expertise was required. In addition, two nurse practitioners lead a monthly case mentoring review at the facility, which provides staff with an in-depth discussion of a range of clinical, professional and ethical issues. A number of registered nurses are engaged in post graduate study, and the clinical coordinator has recently completed a master’s degree in nursing.  The doctor and nurse practitioner interviewed both stated they were satisfied with care provision standards at the service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A review of selected accident/incident forms and resident progress notes within the electronic resident management system confirmed open communication with residents and/or their families. There was also evidence of resident/family input into the care planning process. Family members interviewed stated they were informed in a timely manner about any changes to the resident’s status, and felt fully involved in all aspects of care planning and evaluation.  The clinical coordinator advised that interpreter services were able to be accessed via the local DHB when required, and that the service had also paid for interpreter services in the past for specific residents. In addition, the service employs a number of staff who also speak other languages, and they were available if interpreters were required.  Minutes were sighted of the monthly residents’ meetings, which provide a further opportunity for communication with residents. Regular resident newsletters are also published. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | TerraNova Home and Care Limited is the governing body and is responsible for the services provided at Riverleigh Residential Care (Riverleigh). The current business plan has a philosophy that reflects a resident and family centred approach, mission statement, vision, purpose and objectives.  The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service. The facility manager shares weekly reports via a teleconference with other managers within the TerraNova group. The meetings are facilitated by the chief executive officer (CEO). Meeting minutes include areas of risk, quality improvements, staffing, and occupancy.  The facility is managed by an experienced and suitably qualified manager who is a registered nurse and has been in this position for 12 months. The facility manager is supported by an experienced clinical coordinator/registered nurse. The clinical coordinator is responsible for oversight of the clinical service in the facility. Support is provided by the CEO from TerraNova head office.  Riverleigh is certified to provide rest home and hospital level services. The provider has made application to the Ministry of Health to extend the scope of services provided to include services for residents aged under 65 years with a physical disability. On day one of this audit there were 26 hospital residents, 24 rest home residents and five residents under the age of 65 years with a physical disability. (Three residents have been assessed as hospital level care and two residents as rest home level care.)  Riverleigh has contracts with the district health board (DHB) to provide ‘Short Term Residential Care’, ‘Long Term Support Chronic Health Conditions’ and ‘Aged Related Residential Care’. Riverleigh also has a contract with the Ministry of Health to provide ‘Residential Non Aged Care’.  Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements. |
| 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 | In the absence of the facility manager, the clinical coordinator deputises with support from the administrator. When the clinical coordinator is absent, the facility manager with support from the registered nurses take responsibility for clinical over sight. The facility manager and the clinical coordinator confirmed their responsibility and authority for these roles. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan guides the quality programme and includes goals and objectives. Electronic systems are used to gather and access quality data. There was evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. Corrective action plans are being developed, implemented and reviewed. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. The resident satisfaction survey has been completed for 2016 and results indicated that residents are satisfied or very satisfied with the services provided.  The facility manager provides weekly reports to the CEO. The clinical coordinator stated quality data, including benchmarking with other facilities within the group is discussed at the monthly staff and registered nurse meetings. Meetings are also held with caregivers and heads of departments. Reporting of various clinical indicators and quality and risk issues was sighted in meeting minutes. Care staff reported that copies of meeting minutes are available for them to review in the staff areas. The younger residents with disabilities confirmed they are able to make choices and decisions concerning services. They also stated any suggestions they make about equipment or care is considered by the facility manager.  A newsletter is produced from the TerraNova head office which keeps residents and families informed with what is happening within the TerraNova group.  Policies and procedures are relevant to the scope and complexity of the service; reflect current accepted good practice, and references legislative requirements. Policies and procedures are reviewed by management and are current. Staff confirmed that they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.  Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Hazards and safety issues are discussed at the monthly staff meetings and at the three monthly steering group teleconference meetings with the CEO, meeting minutes confirmed this. Staff confirmed they understood and implemented documented hazard identification processes. |
| 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 | Adverse, unplanned or untoward events are documented electronically by staff. Collated data is analysed by the facility. Documentation is saved on the shared drive and is available to head office for further analysis and follow up. Data includes summaries and registers of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.  Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The facility manager confirmed there have been no essential notifications to the Ministry of Health since the last audit. Staff confirmed they are aware of reporting requirements. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and police vetting.  The clinical coordinator is responsible for managing the in-service education programme. In-service education is provided for staff at least monthly and includes education relating to younger people with physical disabilities. Individual records of education are maintained as are competency assessments.  Care staff are encouraged to complete a New Zealand Qualifications Authority education programme. The clinical coordinator is the internal assessor for the programme.  There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.  Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.  Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. Each of the permanent registered nurses have completed the interRAI assessment programme education. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager and the clinical coordinator are rostered on-call after hours. Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents, including younger residents with a physical disability, and family reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All aspects of consumer information management meet required standards.  Every components of the residents’ records reviewed included the resident’s unique identifier. The hard copy clinical records reviewed were well-organised and integrated, including information such as medical notes, hospital discharge summaries, allied health reports, laboratory results and the resident’s current interRAI (assessment system) report. These records are kept in locked cabinets in the two nursing stations when not being used. The names of people making entries into the hard copy records was legible and their identity clear.  A comprehensive electronic resident management system includes extensive resident information. This system is password protected, with designated staff only able to access information directly related to their role. All aspects of resident care are documented using this system, including assessments, care planning, and evaluation of resident progress towards identified goals, observations and monitoring, wound care and incident/accident forms. The identity of any person making an entry into this system is immediately available. A registered nurse makes an entry into the progress notes daily. Caregivers document the care provided to the resident and normally only update progress notes when exceptions to planned care or resident responses occur. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The clinical coordinator advised that residents can only be admitted once their required level of care has been assessed and confirmed by the Needs Assessment and Service Coordination Service.  Prospective residents and their family/whanau are encouraged to visit the facility prior to admission. They are provided with detailed information about the service, including the admission criteria and the processes that must be completed prior to admission (information package sighted). Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process. |
| 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 uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. When a resident is transferred the clinical coordinator advised that the electronic resident management system can automatically populate a detailed resident transfer form, which is sent with the resident together with other information such as a copy of their medication chart. A copy of a completed transfer form was sighted in a resident’s record, and it contained comprehensive information. Referral to specialist health services, such as services for older persons, is usually made via the resident’s doctor. |
| 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 | All aspects of medication management comply with legislative requirements and safe practice guidelines. Registered nurses and senior caregivers administer medication. All these staff have been assessed as competent in medication administration and records of competency assessments were sighted. Occasionally agency staff undertake medication administration and the CEO explained that the contract with this agency include processes to ensure those staff were medication competent.  Medications were charted in an appropriate manner, discontinued medications initialled and dated, medications were reviewed at least three-monthly and medication administration records were complete. The service does not use medication standing orders. Appropriate processes were in place to ensure the safety of one resident who had been assessed as competent to self-medicate.  Medications are supplied to the facility using robotics medication packaging. Evidence was sighted that these packs are checked against the medication chart by a RN on arrival to the service. The date of first use of eye drops was recorded on those products currently in use. A stocktake of all controlled medication is undertaken weekly. Records of the daily check of the two medication fridge temperatures were sighted, with the fridge temperatures being maintained within an appropriate temperature range.  An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. All medication charts contained a current photograph of the resident, the medication was checked against the medication chart prior to verbally confirming the resident’s identity before the medications were administered; the medications were observed being taken; and then the administration documented. All medication administration records sighted were complete. |
| 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 | All aspects of nutrition, safe food and fluid management meet best practice and legislative requirements.  A qualified chef is responsible for food services, and all kitchen staff have completed food safety training, as confirmed in staff records. On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. Cleaning schedules were sighted, and there were records of daily monitoring of fridge and freezer temperatures.  The service operates on a four weekly menu cycle, with summer and winter options. The menus were last reviewed by a registered dietitian in April 2015. A range of nutritional requirements can be accommodated, including diabetic, vegetarian and soft diets. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly, results entered into the electronic resident management system and there was evidence of systematic monitoring of resident weight loss/gain, with a protocol that guided staff about the action to be taken in relation to percentage weight loss/gain. The clinical coordinator advised that food/fluid intake charts were used for residents as clinically indicated.  Two dining rooms are available for residents or they may have meals in their own room if they wish. Residents stated that they enjoyed the meals, and appreciated having a choice of main meals each day. |
| 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 | If a prospective resident does not meet the entry criteria, or there is currently no vacancy, the clinical coordinator stated that they would work with them and their family to support them to find appropriate care/placement. This usually involves referral back to the Needs Assessment and Service Coordination service, and information about how to access details of facilities with vacancies via the internet. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The clinical coordinator outlined the timeframes for resident assessment. A registered nurse completes the initial assessment and care plans within 24 hours of admission. Within three weeks of admission a registered nurse completes an interRAI assessment, and integrates this into a long term care plan, together with other information such as that provided by the resident/family, the NASC assessment and any relevant referral information. In all residents’ records reviewed, assessment timeframes had been met and there was evidence of all required assessments having been completed.  Five nursing staff have completed the interRAI training, and all residents have a current interRAI assessment, which is reviewed six monthly, or earlier if residents’ needs change. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The individualised resident care plans are comprehensive. Although completed using the electronic resident management system, a hard copy of the current clinical plan is easily accessible for care delivery staff. The plans are detailed, well-organised, and contain a wealth of information and strategies to guide care. Plans reflect comprehensive assessment of residents’ abilities/needs, as well as resident/family input. There is a strong emphasis on promoting and maintaining resident independence, and on tailoring the care plan to meet individual needs. This was sighted in all of the resident records reviewed. Residents and families stated they felt included in the development of these plans, and their ongoing evaluation. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Service delivery is guided by clinical policies/procedures, regular and ongoing assessment and review of resident needs, and evaluations of progress towards meeting identified needs. Documentation related to the care provided to residents is detailed and systematic, and evidence was sighted in the clinical records of ongoing assessment, planning and evaluation of care. The clinical coordinator also explained how a range of specialist health services, such as dietitians, physiotherapists, palliative care, mental health and services for older people, were accessed to help ensure that residents’ needs were met. Registered nurses are on duty 24 hours a day to provide support and guidance for care delivery staff.  Three health professionals, a general practitioner, nurse practitioner, and dietitian, all expressed their satisfaction with the services provided to residents. |
| 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 newly appointed activities coordinator, who has had previous experience as an activities assistant, is responsible for coordinating the residents’ activities programme. The coordinator, who works full-time, is assisted by a part-time activities assistant (30 hours each week).  Residents’ previous and current interests are assessed on admission and individual activity plans completed within three weeks and reviewed six monthly. This was confirmed in residents’ records. These plans help inform the development of the monthly activity programme. Activities are offered on a one-on-one basis, and also in a group format. Recent activities available to residents include games, quizzes, exercises, ‘blokes shed’, crafts, bowls, knit group and garden club. Outings are organised at least monthly, and church services are held twice a month. Once a fortnight, children from a nearby day care centre visit residents, who enjoy reading to them.  The activities coordinator is currently establishing a ‘young ones’ group for residents aged under 65 years. The group meets twice weekly, and participants are currently identifying what activities would be appropriate for them. Several of these residents are able to independently access activities in the community, and this is encouraged.  The activities coordinator runs the monthly resident meeting, which includes discussion of the activities plan, and suggestions for new activities.  Resident interviewed stated they enjoyed the activities on offer, although the younger residents welcomed the current initiative to help plan activities tailored specifically to their needs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The clinical coordinator advised resident progress towards identified goals was evaluated at least six monthly, in conjunction with the six-monthly interRAI reassessment. Short-term care plans were identified as clinically indicated but usually at least weekly. Wound management plans were evaluated each time the wound dressing was changed. These timeframes were confirmed in all care plans reviewed. Evaluations were completed by registered nurses, and were detailed. When changes to resident needs were identified as part of the evaluation process, care plans were updated accordingly. |
| 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 right of residents to access other health and/or disability providers is maintained. The clinical coordinator explained that although the service does have a ‘house doctor’ residents are able to choose who will provide their medical services.  If the need for other services is identified, the doctor or a registered nurse sends a referral to seek specialist provider assistance, and copies of such referrals were sighted in the resident records. These included referrals to the dietician, palliative care services, diabetes specialist nurse and wound care specialist.  Residents and family members confirmed on interview that they are kept informed about the referral processes. Support is available to transport and accompany residents to external health-related visits, as sighted in resident records and confirmed during interviews with families. |
| 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 documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The hazard register is current. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.  There is protective clothing and equipment appropriate to recognised risks. There was protective clothing and equipment sighted in the sluice rooms and the laundry and being used by staff. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness was displayed. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. There are wide passage ways and handrails to enable residents with physical disabilities to move freely throughout the facility. All residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.  There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The maintenance person and observation confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.  There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.  Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.  Residents confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents also confirmed they are able to move freely around the facility and that the accommodation meets their needs. |
| 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 | A number of bedrooms have either full ensuites or ensuites consisting of a wash hand basin and a toilet. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access. Younger residents with a physical disability have full ensuites and reported easy access to these.  Appropriately secured and approved handrails are provided and other equipment is available to promote resident’s independence. |
| 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 is adequate personal space provided for residents and staff to move around within the bedrooms safely. There is a mix of single and double rooms. Three of the seven double rooms are used by couples. The other four rooms currently provide single accommodation. Residents, including younger residents with a physical disability, spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.  There is room to store mobility aids such as mobility scooters and wheel chairs. |
| 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 are a number of areas for residents to frequent for activities, dining, relaxing and for privacy. These areas are easily accessed by residents including younger residents with a physical disability and staff. Residents confirmed this. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Younger residents with a physical disability reported they enjoy participating in activities with the older residents and enjoy their company. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is washed off site by an external contractor who picks up and returns the laundry daily. Residents and family reported the laundry is managed well and resident’s clothes are returned in a timely manner. One of the cleaners is responsible for making sure the laundry is ready for pick up.  There are dedicated cleaners on site who have received appropriate education. Interview of one of the cleaners and training records confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations and covers all service groups provided at the facility. A fire drill takes place six-monthly with a copy provided to the New Zealand Fire Service. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures.  There is always at least one staff member on duty with a current first aid certificate.  All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQ’s.  There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.  Contractors must wear names badges and sign in and out of the facility. They are also made aware of any hazards on site.  The external doors are locked in the evenings. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by central heating. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Infection control management is appropriate to the size and scope of the service. Infection control management is guided by a comprehensive infection control manual, developed at organisational level. The manual is reviewed annually, with the CEO advising that a review of the manual is currently being completed.  The clinical coordinator is the designated infection control coordinator. Infection control matters, including surveillance results, are reported monthly to the facility manager, and to the organisation’s clinical quality and risk advisor. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. This was confirmed in staff interviews. There are adequate supplies of personal protective equipment available to staff.  A sign at the main entrance to the facility asks anyone who is or has been unwell in the past 48 hours to not enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. |
| 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 control coordinator (clinical coordinator), has appropriate skills, knowledge and qualifications for the role, and has been in this role for five years. There are also well-established networks with the Public Health Unit and the infection control team at the DHB if additional support/information is required. The coordinator advised that in their infection control capacity they have access to residents’ records and diagnostic results to ensure timely treatment and resolution of infections.  Protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted).  While the facility does not have a separate infection control committee, infection control matters are discussed at the weekly management team meeting consisting of all heads of departments, and at the monthly staff meeting. |
| 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 | A comprehensive policy/procedure manual guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. The manual is currently being reviewed, as confirmed by the CEO.  Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate. Housekeeping and kitchen staff were observed to be compliant with generalised infection control practices. Hand sanitiser dispenses are readily available around the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Annual infection prevention and control education has been provided to staff, as confirmed in staff training records and the annual education plan. Infection control is also a component of the staff orientation programme. This education is provided by suitably qualified registered nurses, including the infection control coordinator. If there is an infection outbreak or an increase in infection incidence, the infection control coordinator advised that additional staff education would be provided. Education with residents is generally on a one-to-one basis. This may include reminders about handwashing or advice about remaining in their room if they are unwell. |
| 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 | Surveillance is undertaken on a monthly basis of a range of infections, including urinary tract, soft tissue, eyes, gastro intestinal, upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the electronic resident management system. The infection control coordinator can review infection-related information at any time. The infection surveillance data is collated monthly, and reported to the facility manager. The surveillance report is incorporated into the monthly risk management report at an organisational level, and benchmarked across the organisation and with other aged care providers.  Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service demonstrated that the use of restraint is actively minimised and there has been no residents using restraints since the beginning of 2015. There were eight residents using an enabler. The restraint coordinator is a registered nurse and demonstrate good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have good definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.  There is a restraint minimisation steering group comprising of restraint coordinators from all the TerraNova facilities that meet via teleconference three monthly. Comprehensive meeting minutes confirmed this. |

# 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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| No data to display |

# 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.