

Rosaria Rest Home 2006 Limited

Introduction

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

The audit has been conducted by 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](#).

The specifics of this audit included:

Legal entity:	Rosaria Rest Home 2006 Limited
Premises audited:	Rosaria Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 April 2016 End date: 19 April 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	23

Executive summary of the audit

Introduction

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

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

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

Indicator	Description	Definition
Yellow	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
Red	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

Rosaria Rest Home is privately owned and provides rest home level care for up to 26 residents.

This spot surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of relevant policies and procedures, the review of staff files, observations, and interviews with residents, families/whanau, management and staff, and the General Practitioner.

All interviews with staff, residents and families were undertaken using an interpreter. The majority of residents and staff are of Chinese origin.

There has been a change since the last audit and this includes the unavailability of the quality advisor and the resignation of the RN. There was only one area for follow up from the previous audit.

The District Health Board (DHB) and Ministry of Health (MOH) were notified within 24hours about the four standards identified as high risk, these relate to risk management, safe staffing levels, timeliness of GP assessments of new residents and safe medication storage.

The areas for improvement are in adverse events, collecting data and analysing it as part of the quality and risk programme; staff appraisals and staff education. Improvements are also required in change of health status, safe food services and catering for residents likes and dislikes.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Evidence is seen of open disclosure as part of documentation review of resident files. This includes on admission and ongoing care plan evaluation. Informed consent forms are signed as part of the admission process.

An area for improvement relating to complaints management is required. There is no up to date complaints register or evidence that complaints are followed up as part of the quality system.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Rosaria Rest Home has a business plan which covers all aspects of service delivery planning. The business plan is reviewed annually by the director/manager. The mission statement and philosophy are documented and reflected in the quality and risk management system.

The quality and risk management systems, which include internal audits, complaints management, incident and accident processes and infection control have not been implemented since the last audit. No evidence is seen of quality management data being reviewed at quality or staff meetings.

An area for improvement is required relating to safe staffing levels. Not every shift is covered by a staff member who holds a current first aid certificate. An area for improvement is required as staff appraisals are completed and no evidence is seen of a suitable person undertaking the appraisals for clinical staff.

A staff education programme is available but there is no evidence of the education sessions being evaluated or the content being available for review.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Timeframes are met for nursing care assessments, care planning and evaluations. Residents are assessed on admission by the registered nurse (RN) and an interim care plan is developed within the required timeframes. The GP has not assessed residents following admission within the required timeframe. Neither the director/owner nor the RN were aware of this requirement.

The care plans clearly document the day to day interventions that each resident requires to meet their needs. The care is evaluated at least six monthly, or sooner if there is a change in the residents' needs. Short term care plans are used by the service. The service does not demonstrate current good practice related to ongoing observations for residents who have a fall.

The activities offered are undertaken by community groups and services who are contracted for four and a half hours per week. All activities offered are provided by Chinese speaking providers. The service does not have an up to date plan of any activities offered over and above what is provided by the contracted services and there is no nominated activities coordinator employed. Residents stated they enjoyed the activities that were offered.

There are documented processes in place for safe medicine management. Staff responsible for medicine management are assessed as competent to perform the function for each stage they manage. The medication room is not securely locked and medications are easily accessed by any person who enters the medication room.

There is a menu in place for European and Chinese meals offered on a daily basis. Several issues have been identified related to food services. There is no evidence that the menus in place have been approved as meeting recognised nutritional guidelines for aged care. Resident's special needs and likes are not always met. Not all stored food shows a best by or expiry date on it and decanted food is not labelled.

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.
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The building has a current building warrant of fitness. There have been no changes made to the building footprint since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

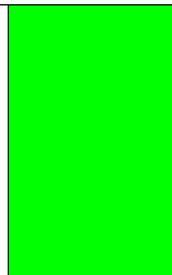


Standards applicable to this service fully attained.

There are no restraints or enablers in use at the time of audit. Policy describes enablers as being voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

Infection prevention and control

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.

Surveillance for infections is conducted monthly. Results of surveillance, conclusions, and specific recommendations are used to assist in achieving infection reduction and prevention outcomes as required. Infection control data is reported to staff and management in a timely manner.

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	6	0	1	5	4	0
Criteria	0	14	0	2	5	7	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	2	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The complaints policy at Rosaria rest Home is relevant and meets legislative requirements. Evidence was not seen of Rosaria Rest Home implementing the complaints policy and procedure to ensure all complaints are actioned according to the policy. The complaints information sighted was in a book for minor complaints and closed off but not addressed as part of the quality system.</p> <p>Using an interpreter, staff reported on interview they would talk to the RN with any complaints but did not know about complaints forms and they did not recall complaints being discussed at staff meetings. No evidence of complaints being a regular agenda item for staff meetings.</p> <p>The residents on interview reported they would talk to the manager but were not aware of process or policy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Evidence was seen in residents' files of family contact regarding changes to care needs. Using an interpreter residents and families reported that they are informed and given choices about care. Staff reported that they contact family when the residents' care needs change or there has been an incident. An interpreter is available when required.</p> <p>Consent forms are signed as part of the admission process and as required. Sighted in all files</p>

		reviewed.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business plan sighted is reviewed annually. This was last undertaken in January 2016. There are specific goals and objectives covering all aspects of the business and quality planning for Rosaria Rest Home. The quality and risk plan details the known risks, current controls and ongoing actions taken to limit risk. The mission statement and organisational philosophy are documented.</p> <p>The owner/director has owned the facility since 2006 and is responsible for all non-clinical services. There is a registered nurse who has worked at the facility three years. This is her first position in NZ. Prior to this she has had no experience in aged care. The manager/director attends ongoing education sessions at the DHB and has completed a small business programme. The previous area for improvement has been addressed.</p> <p>The director/manager reported on interview he has understanding of legislative requirements with regard to business and building compliance but he is reliant on the RN to have this knowledge regarding care, no evidence is sighted of implementation of care legislative requirements.</p> <p>Interviews using an interpreter occurred with residents and confirmed that their needs are met.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA High	<p>All aspects of the quality and risk system have not been implemented since the last audit. Staff interviewed, using an interpreter, understood the need for incident forms but did not understand the continuum of quality care. There are processes which include regular internal audits, incident and accident reporting, infection control management and data recording and complaints but these have not been kept up to date since the last audit. No evidence is seen of monthly quality data evaluations and corrective action.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	PA Moderate	<p>Policy is in place to inform staff about how to manage adverse event reporting. The service records incidents and accidents but no evidence was seen of this being used as part of the quality system. There is no evidence of discussion in staff meeting minutes sighted. Staff interviewed reported that they understand reporting of adverse events using incident and accident forms.</p> <p>No documented evidence is sighted that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Incident and accidents are reported to family as confirmed on the incident and accident forms sighted.</p> <p>The manager confirmed their understanding related to the obligations in relation to mandatory</p>

		notification requirements.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation, are implemented by the service. Job descriptions clearly describe staff responsibilities and accountabilities. The individual contracts, terms and conditions were not sighted in any of the staff files reviewed but the director/owner reported he keeps them at his home.</p> <p>Staff files reviewed identify that staff have completed an orientation programme with specific competencies for their roles.</p> <p>The owner/director has completed all appraisals but there is no evidence that the employee was involved as no signature was sighted on the appraisal form. Staff report on interview that education is held as part of the staff meetings but are not aware of any evaluation or handouts of content of the session.</p> <p>Evidence is seen of staff that require professional qualifications have them validated as part of the employment process and annually.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA High	<p>The service does not provide safe staffing levels to meet legislative requirements. This is reflected in the rosters sighted that contractual requirements are not met. Every shift is not covered by a staff member with a current first aid certificate.</p> <p>A review of the rosters showed that staff are replaced when on annual leave or sick leave. Staff interviewed reported that they sometimes do not complete their workload but are busy. This was discussed with management who stated they understand that there is often a variance in the required hours depending of resident acuity and needs.</p> <p>Residents interviewed confirmed during interview that services are delivered in a safe, timely and homely manner and that residents needs are met.</p> <p>The RN works Monday to Friday and is on call. There are dedicated kitchen and cleaner/laundry staff.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA High	<p>The service has a system in place to ensure residents receive their medication in a timely manner that complies with current legislative requirements.</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>There were no controlled drugs or standing orders used at the time of audit. All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Current medication competencies were sighted for all staff who assist with the medicine management.</p> <p>Medication charts are hand written and a discussion was held regarding the possibility of getting the pharmacy to provide printed medication charts in the future as they are easier to read and this is now considered as good practice. The RN stated she would look into this.</p> <p>The RN reported that there are three residents who self-administer their medicines. The service implements policies, procedures and self-administration guidelines to assess if a resident was competent to administer their own medicines. This process was well managed. One resident interviewed who self-administered some of their medication was able to describe safe procedures and what the medication was for.</p> <p>The storage of medications is not secure and this is an area identified for improvement.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The menu sighted was updated on 17 February 2016 but this has not been reviewed by a dietitian as suitable for the older person living in long term care. Residents were routinely weighed at least monthly, and more frequently when indicated. Information sighted in the kitchen regarding residents with additional or modified nutritional needs or specific likes and dislikes was out of date. All but one resident reported satisfaction with the meals and fluids provided.</p> <p>All aspects of food procurement, production, preparation, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and met requirements. Stored food in the cupboard and fridge is not clearly labelled and in some cases not labelled at all. There were no best before or use by dates that could be found on stored food that had been decanted. Some of the containers had use by dates on them which had long expired. There was no cleaning schedule for the kitchen.</p> <p>Evidence was seen that two of the three kitchen staff had completed safe food handling certificates. The third person in the kitchen had not completed this for over five years but she has resigned and is working out her notice.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	<p>PA Moderate</p>	<p>The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. Regular ongoing care interventions are documented on the care plan. However, the facility does not follow current good practice related to management of residents following a fall. For example, neurological observations are not carried out for unobserved falls or falls with a head</p>

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>injury.</p> <p>InterRAI assessment triggers are not printed but the RN stated she uses the electronic information when planning residents' cares. This is consistent with documentation sighted which showed assessment information has been used to completed care plans.</p> <p>Residents and family/whānau interviewed reported satisfaction with the care and service delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>PA Moderate</p>	<p>The resident's initial assessments include social likes and past interests. This information is not well used by the facility. The service uses outside groups and services to provide the activities presents. The people who present them are contracted to do so on a regular basis and they are all presented by people who speak Chinese and who present activities which meet residents' cultural needs. The activities plan sighted was out dated.</p> <p>Feedback about what residents want to do is sought at the residents' meetings as confirmed in meeting minutes sighted. During interview residents stated they wanted to go on outings. No other wishes were identified as they were happy with what is being offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The care evaluations record how the resident is progressing towards meeting their goals. The files reviewed evidenced at least six monthly evaluations of care, or sooner if there were any changes to the resident's care or condition.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans and infection reports were sighted in the files reviewed.</p> <p>The GP, residents and family/whānau interviewed reported satisfaction with the care provided at the service.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation reviewed identified that all processes are maintained for the facility's current building warrant of fitness which expires on 10 June 2016. There have been no changes made to the footprint of the building since the previous audit.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The service conducts monthly surveillance for infections and uses standardised definitions of infections that are appropriate to the long term care setting. The infection control programme and policy are fully implemented. The data sighted for 2015-2016 identifies that infection rates are low and remain stable. The RN was able to verbally describe actions to be taken should infections rise or if an outbreak occurs.</p> <p>The staff meeting minutes show that infection control data is shared at staff meetings. The resident meeting minutes identify that infection control education, such as reminding residents to wash their hands prior to meals, occurs.</p> <p>There have been no recorded outbreaks since the pervious audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policy clearly described enablers as voluntary and the least restrictive option to meet residents' needs. The facility was restraint free at the time of audit and there are no enablers in place. Staff confirmed during interview that the annual education undertaken has given them a very clear understanding of what is required should any form of restraint be required.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>No complaints register was sighted and no evidence was seen of complaints being part of regular staff meetings.</p> <p>Finding:</p>	<p>There was no evidence of the complaints process, for example, no complaint forms were available, no public information about the complaints process, and there was nowhere to deposit a completed complaint form. The provider was not responding to verbal complaints within five working days. A minor complaints book was available that captured some complaints issues. There was no complaints register, and no evidence of complaint management since the last audit.</p>	<p>Ensure an up to date complaints register is maintained and correct process followed as per the policy.</p> <p>90 days</p>

			There is no evidence of complaints and outcomes being linked to the quality system. Staff reported on interview they speak to the RN but are not aware of the process. Residents reported on interview they would talk to the manager but were not aware of a correct process.	
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA High	There is no evidence that since the last audit the quality and risk management system has been managed.	<p>Since certification audit in 2014 the Quality Consultant has been unwell and the RN has resigned. The quality processes since that time show no evidence of ongoing quality and risk management being part of this organisations practice.</p> <p>The new RN on interview does not report to have an understanding of the quality systems.</p> <p>The director/ owner also has limited knowledge of quality and risk management however has completed audits regarding building compliance. No other areas have been maintained.</p> <p>Throughout the quality and risk system a breakdown has occurred over the last eighteen months. Refer to findings in 1.1.13.3, 1.2.3.6, 1.2.3.8, 1.2.7.5</p>	<p>Re-establish the structure, process and reporting systems for quality and risk management. Ensure there is a staff member, or Quality Consultant who has relevant knowledge of quality systems and the audit process.</p> <p>30 days</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>UA High</p>	<p>No documented evidence is seen of data being analysed and evaluated as part of the quality system in meeting minutes or the continuous improvement programme.</p>	<p>Some data is collected but not evaluated or analysed as part of the quality system. Staff interviewed using an interpreter reported no knowledge of discussions at staff meetings.</p>	<p>Ensure data collected analysed as part of the quality and risk programme.</p> <p>90 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>UA High</p>	<p>No evidence is seen of a process being implemented that measures quality and risk.</p>	<p>Since the last audit there have been no process implemented to measure quality and risk. Only building compliance audits are completed and no evidence is seen of assessment and any quality improvement measures. Staff interviewed using an interpreter were not able to report on any discussions at meetings or education.</p>	<p>To re implement quality and risk processes which meet the policy and legislative requirements.</p> <p>30 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA High</p>	<p>No evidence is seen of corrective action plans being addressed as part of the quality system.</p>	<p>No corrective action plans sighted for any areas identified for improvement. This includes adverse event reporting, and infection control audit results</p>	<p>Implement corrective action plans as part of the quality risk management programme. Ensure feedback is given to staff as part of the education and quality</p>

				programme. 30 days
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA High	No evidence is seen of risks being identified or being communicated to residents or family.	The quality system is not part the meetings with families or residents. The includes results of audits or incidents forms	Implement the process to ensure consumers are aware of any risks identified as part of the quality process. 30 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA High	Adverse events are recorded as incidents and accidents but are not used to improve service delivery or to identify and manage risk.	<p>Adverse events are recorded as incidents and accidents but not used to improve service delivery or to identify and manage risk.</p> <p>An example is one resident who knocked their head was not observed for neuro observations and now is in hospital.</p>	<p>Ensure use of adverse event data is used to improve service delivery and to identify and manage identified risks.</p> <p>Ensure each</p>

				<p>incident is reported and reviewed to ensure changes are part of the quality system.</p> <p>30 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	No evidence is seen of employees having input with annual appraisals. No content or evaluation of education sessions sighted.	<p>Staff annual appraisals are completed but no evidence of clinical input or staff signoff could be sighted. There is currently no staff member with suitable qualifications undertaking appraisals which require a clinical assessment two yearly. Education programme is sighted but no evidence is seen of content or evaluation. Staff report on interview they attend education as part of the monthly staff meetings but are not aware of evaluations or handouts with content of the session.</p>	<p>Ensure appraisals are undertaken by an appropriate staff member and that staff input is identified. Ensure education has documented content and sessions are evaluated. Ensure the clinical requirements of the appraisal are completed and signed by a relevant clinician.</p>

				365 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	<p>The staff member who undertakes the sleep over role on night duty has a first aid certificate but the location for sleep over is outside the main facility. No allocated time is seen of days off for this staff member. The staff member works 130 hours per fortnight plus 14 nights as a sleep over from 11pm to 7 am. On interview the caregiver reported being at work from 5am so that her duties can be completed.</p> <p>There is one hospital level resident who has been approved by the MOH in 2014 but has not been reassessed since that time (refer finding 1.3.3.3). This resident requires two person care, and due to staffing levels this is not always available unless the “sleepover” is awoken during the night.</p>	<p>The service does not provide safe staffing to meet legislative requirements.</p> <p>To meet DHB contractual requirements there is to be one staff member on each shift with a first aid certificate. The employee detailed above is the only person with a First aid certificate.</p>	<p>Ensure safe staffing levels are implemented at all times as identified in policy and required by the DHB.</p> <p>30 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA High	<p>Most of the medicines are supplied by the pharmacy in a pre-packed sachet administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. Safe medicine administration was observed at the time of audit. The GP reviews are undertaken at least three monthly.</p> <p>The fridge where medications are stored is monitored for temperature daily, with the sighted temperatures within safe medicine storage guidelines.</p> <p>The storage of medications is not secure. There is a</p>	<p>The medication room door is not securely locked and medication is accessible to anyone who enters the room. The medication folders are kept on top of the fridge and not in one of the locked cupboards in the room. The director/owner stated the medication folders used to be kept in the cupboards but this practice has ceased. During interview with the RN and the manager/director they stated that the medication door was not locked so the room could be easily accessed by all staff during the day. They indicated</p>	<p>Ensure the medication room is secure at all times.</p> <p>1 days</p>

		<p>lock on the medication room door which was not used by staff during the day of audit. There is a cabin hook on the top of the door which staff use. The actual pharmacy folders with the pre-packed sachet medication for residents are kept on top of the fridge and can be accessed by whoever enters the medication room.</p> <p>Following a discussion with the RN and the manager/director about the need to keep medication secure at all times they stated they understood what was required and that they would ensure all staff were informed. They were going to advise all staff who administer medications that the key lock must be used and that medication supplies need to be kept in the locked cupboard.</p>	<p>their understanding of what was required to fix this problem.</p>	
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>The menus sighted show that there are two daily options for residents one is European food and one is Chinese food. On the day of audit there is one cook for each type of meal. The menu had been updated by a staff member who recently completed level five in advanced food safety. However, the menu has not been approved to identify that it is in line with recognised nutritional guidelines for aged care.</p>	<p>Menus have not been approved to show they meet recognised nutritional guidelines for an aged care environment.</p>	<p>Provide evidence that menus have been approved a suitable for aged care.</p> <p>90 days</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	PA Moderate	<p>A nutritional assessment is undertaken for all residents. If they require additional or modified nutritional requirements or a special diet this information is passed onto staff in the kitchen. However, the documented information sighted on the day of audit was outdated and two of the residents on the list were no longer at the facility. (The document sighted was not dated). One resident informed the auditors that they disliked the</p>	<p>The information related to residents' dislikes could not be found and nutritional requirement documentation located in the kitchen was out of date.</p>	<p>Ensure information related to residents who have additional or modified diets are kept up to date and that</p>

		vegetables being served and that the kitchen were aware of this. The resident gave examples of other food they did not like and yet it was still given to them by the kitchen. When the kitchen staff were asked about this they said they were too busy on the day of audit to meet the resident's needs. They said they were aware of the resident's likes and dislikes. No documentation could be located in the kitchen to show any residents' likes or dislikes.		all residents' likes and dislikes are catered for. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	Food is purchased so that the documented menu can be used. This task is undertaken by management. All food is prepared on site. Food is disposed of via use of a waste disposal unit. The food stored in the fridge was not dated or labelled to say what it was. The food in the cupboard had been decanted and no expiry date or best by dates could be seen. Some containers had dates on them but they were pre August 2014. Both the cooks stated the supplies had been replenished many times since then. The kitchen floor had a build-up of dust and dirt around the fridges. There is no documented evidence of when the extractor fans were last cleaned. There is no documented cleaning schedule in place. The staff interviewed stated the kitchen is cleaned daily.	The food stored in the cupboard and in the fridges does not have an expiry date or best by date shown. There is no documented cleaning schedule for the kitchen area.	Provide evidence that food storage is undertaken to meet best practice guidelines and meets current legislative guidelines. This includes the introduction of a documented regular cleaning schedule 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review,	PA High	Nursing assessments, planning provision, evaluation, review of service is provided within required time frames. However initial timeframes for admission of residents is not being met by the GP. Ongoing medical review timeframes such as	Three of three recent admissions (covering 2015 and 2016) do not meet the requirements of the DHB contract for admission	Provide evidence that newly admitted residents are

<p>and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>monthly or three monthly if the resident is stable are met. Interviews with residents and family/whānau confirmed all their needs are well met by the service.</p> <p>Initially only five residents' files were reviewed. This number was extended owing to GP admission timeframes not meeting the requirements of section D16.5ei1 of the Age Residential Care Service Agreement with the DHB</p>	<p>within two working days.</p> <p>Examples sighted:</p> <ol style="list-style-type: none"> 1. admission date 14 November 2015 GP admission 23 November 2015 2. admission date 11 February 2016 GP admission 17 February 2016 3. admission date 09 July 2015 GP admission 19 August 2015 <p>This was discussed with the RN who stated she was unaware of the two working days' post admission requirement so she has never asked the GP to meet this requirement. The director/owner also stated he was not aware of this requirement.</p>	<p>seen by a GP within the required timeframes.</p> <p>Ensure management and staff with responsibility are aware of and comply with standards and contract requirements.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>The documented interventions are consistent with, and contribute to, meeting the residents' day to day regular assessed needs. However, the interventions to be carried out following a fall do not reflect current good practice. For example, neurological recordings are not undertaken if a fall is unwitnessed or if the resident had a head injury</p>	<p>Following any residents' falls documentation could not be found regarding actions taken and interventions required to monitor the resident's condition. Refer comments 1.2.4.3</p>	<p>Provide evidence that all required interventions are documented to monitor resident change in status.</p> <p>90 days</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>Residents are included in activities undertaken by visiting presenters who are contracted for four and a half hours per week. These include Tai Chi twice a week, singing and a church group who visit. As all the residents at the time of audit are Chinese the activities undertaken reflect and meet their cultural needs. The presenters all speak Chinese.</p> <p>Feedback about what residents want to do is sought from the residents' meetings. Residents stated during interview that they want some outings to occur. They said this used to happen but that outing had ceased. The Director/Manager stated that he intends to re-commence outings. They stopped because he was on holiday. No other activities wishes were voiced by residents or their family/whānau during the audit.</p> <p>The activities plan sighted was out dated.</p> <p>There is no dedicated activities person identified on the roster. One staff member who used to undertake activities stated that they trialed many things such as bowls but owing to the language barrier and residents lack of interest this was ceased. (The staff member is English speaking). This does not meet the requirements of the Age Related Residential Care Service Agreement clause D16.5 with specific requirements to have a designated staff member who is skilled in and accountable for assessment, implementation and evaluation of social, diversional and motivational recreation programmes for each subsidised resident.</p>	<p>The only activity plan located was dated August 2015. Contracted activities are undertaken 4.5 hours per week and there is no nominated staff member responsible for activities.</p>	<p>Provide evidence that there is a suitable qualified staff member who is responsible for undertaking and overseeing activities and who ensures there is a plan for activities undertaken to meet resident identified needs.</p> <p>90 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.