# Sunflower Field Trading NZ Limited - Summerville Rest Home

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

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

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

The specifics of this audit included:

**Legal entity:** Sunflower Field Trading NZ Limited

**Premises audited:** Summerville Rest Home

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

**Dates of audit:** Start date: 13 October 2016 End date: 13 October 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:** 11

# 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

Summerville rest home is privately owned and was purchased by the current owner in October 2015. The manager has been in the role under this and the previous owner for 25 years. The service is certified to provide rest home level of care for up to 15 residents. There were 11 residents on the days of audit.

The certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The manager works fulltime and is supported by a registered nurse with experience in aged care, who has been in the role for over two years.

Residents, families and general practitioner interviewed commented positively on the standard of care and services provided at Summerville rest home.

The certification audit identified that improvements are required around documenting a business and quality plan, review and updating policies, staff employment documentation, care plan, activities and wound care documentation, and medication management.

## 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. |

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Summerville rest home has a quality and risk management system. Key components of the quality management system link to a number of meetings including staff and quality meetings. An annual resident/relative satisfaction survey is completed and there are four monthly resident/relative meetings. Human resource policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. Staff appraisals are in place and are implemented. There is an in-service training programme covering relevant aspects of care and support. The facility staffing policy aligns with contractual requirements and includes skill mixes.

## 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. |

Residents are assessed on entry to the service. There are entry and admission procedures in place which include InterRAI assessments. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whānau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. There is a medication management system in place and each resident is reviewed at least three monthly by their general practitioner. A range of individual and group activities are available and coordinated by the diversional therapist. All meals are prepared onsite and the kitchen is the hub of the rest home. There is a menu in place which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents report satisfaction with the food service.

## 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. |

There is a current building warrant of fitness. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are lounges and a dining area, and small seating areas throughout the facility. Furniture is appropriate to the setting and arranged that allows residents to mobilise.

There is a designated laundry which includes storage of cleaning and laundry chemicals. Chemicals are stored in a locked storage cupboard. The service has implemented policies and procedures for civil defence and other emergencies. A BBQ is available in the event of a power failure. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

## 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. |

Summerville rest home has a restraint free philosophy. There were no residents on restraint or using enablers. Staff education on restraint minimisation and management of challenging behaviour has been provided.

## 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. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. There is a suite of infection control policies and guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

## 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 | 39 | 0 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 7 | 1 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The service has information available on the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). Advocacy pamphlets and the Code are clearly displayed at the main entrance. On interview two caregivers and one registered nurse (RN) were aware of residents’ rights and were able to explain how they incorporated this into their practice. Five residents interviewed stated that their rights are respected. One family member interviewed spoke highly of respect for all aspects of the resident’s rights. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has policies and procedures relating to informed consent and advanced directives (link to 1.2.3.3 for policy content). All five files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. Advocate support is available if requested. Interview with two caregivers confirmed that they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of complaints process. There is a complaint register and complaint forms are available. Information about complaints is provided on admission and available in the service entrance. Discussions with caregivers stated that concerns/complaints were discussed at bi-monthly staff meetings and this was verified on meeting minutes reviewed. Interview with residents and family confirms an understanding of the complaints process. Two complaints have been made since the last audit. The complaints reviewed were managed appropriately with acknowledgement, investigations and responses recorded. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | On entry to the service residents/family receive an information pack that includes a code of rights information and a resident admission agreement. The manager or RN discusses the information pack with the resident and the family/whānau on entry. This includes the code of rights, complaints and advocacy. Health and disability advocacy service leaflets are available to residents and family in the service entrance. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Caregivers interviewed were able to provide examples of how they maintain privacy and dignity for residents and would always report any suspected abuse. Residents and family members interviewed stated they felt their needs, values and beliefs were respected. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. There are guidelines for the provision of culturally safe services for Māori residents and cultural awareness and these include guidelines around the importance of whānau. There is also a list on contact persons for other ethnic cultures if required. On the day of the audit there were no residents who identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service provides a culturally appropriate service by including cultural needs as part of care planning with family/whānau involvement when available. Information gathered during assessment including resident’s cultural, beliefs and values is used to develop a care plan. Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Family are involved in assessment and the care planning process.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Summerville rest home has an abuse and neglect policy (link to 1.2.3.3 for policy content). Residents interviewed reported that the staff showed respect. Elderly abuse and neglect training is included in the annual training plan. Staff contract agreements include harassment and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The manager is committed to providing services of a high standard, based on the service philosophy of care. Staff have a sound understanding of principles of aged care and state that they feel supported by management. Staff report the manager and registered nurse are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RN has access to external training. Discussions with residents and family were positive about the care they receive.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Summerville rest home has an open disclosure policy, which describes ways that information is provided to residents and families. There is an admission pack that gives a range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. This information is discussed at entry and staff are available whenever the resident and family members wish to discuss any aspect of service delivery. The information pack is available in large print and advised that this can be read to residents. Residents and family praised the communication from the management team. Resident/family meetings are held every four months. The activities coordinator holds weekly ‘tea and chat’ meetings with residents which allows the residents to voice concerns in an informal setting. Annual resident and relative surveys are also completed. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Summerville rest home provides rest home level care for up to 15 residents. On the day of the audit there were 11 residents, including two residents on a mental health contract. The manager has been in the role for 25 years. She has a certificate in management. The manager has worked in the health care and aged care sectors for a number of years before this. She is supported by a RN who works 8-10 hours a week. The new owner is a non-New Zealand registered medical practitioner. He has assumed the role of managing director only. The managing director manages the business remotely and is supported by the manager and the RN. He also works with the manager to manage payroll and other financial aspects of the business in consultation with the company accountants. The annual quality and business plan requires further review (link 1.2.3.7).The manager has maintained eight hours of professional development in the past 12 months. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | During a temporary absence of the manager, the RN provides leadership and assumes the manager’s role, with the support from the managing director.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | Summerville rest home has an implemented quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including staff and quality meetings. The staff meetings include discussion around, internal audit outcomes, health and safety, infection control, incident/accidents, complaints and restraint as needed. The minutes of these meetings are documented and include feedback from the quality meeting. The service has four monthly resident meetings and informal resident meetings once a week with the activities coordinator. The activities coordinator documents any concerns on a form to take to the next meeting. There are a range of policies, associated procedures and forms in place. Not all policies and procedures are robust and do not provide in-depth guidance for staff (link 2.1.1 for enabler policy). An annual satisfaction survey is conducted to encourage resident and family feedback. The 2015 survey has been reported back to staff and resident meetings with evidence of changes made as a result of survey feedback. There is a wall planner with a schedule of internal audits. Corrective action format is used for audits, meeting minutes and reports. The service reviews all audits six monthly and action plans are followed up through staff and management/RN meetings. Incident and accident reporting and health and safety are all linked to the quality and risk management system. There is a risk management register. Risks are monitored through implementation of quality activities and reviewed through meetings. The service does not have a current annual business/quality plan in place.  |
| 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 | The service collects incident and accident information. Incidents and accidents are reported and the immediate and appropriate clinical actions taken are documented in incident forms. Incident analysis is reported and monitored though staff meetings and quality/management meetings. Incident forms are retained on the resident file for one month to alert staff to the incident and then they are filed. Review of twelve incident forms document that families have been informed of adverse events.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | There are 13 staff employed by Summerville rest home which includes a manager, a registered nurse, caregivers, cleaner, kitchen staff and the activities officer. The practising certificate for the RN is current. The service maintains copies of the other visiting practitioner’s certification including the general practitioner. Five staff files were reviewed including one manager, two caregivers, one RN and one activities coordinator. Not all staff files reviewed had an employment contract and a signed job description. There is an annual appraisal process in place and appraisals are current in the five files reviewed.New staff complete an orientation that was sighted in four of the five files reviewed. The service has a training schedule for in-service education. The in-service schedule is implemented and attendance recorded at sessions kept, each session includes an attendance sheet. Interview with caregivers indicated there is access to sufficient training. Medication competencies are completed for all staff who administer medication. |
| 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 policy on staff numbers and skills required (link 1.2.3.3). Skill mix is reviewed on a regular basis and reviewed in-line with resident numbers. There are two caregivers on duty in the morning, one full and one ‘tea’ shift in the afternoon and one caregiver overnight. The manager is on site from 7.00am until 3.00pm Monday to Friday and is on call 24/7. There is a RN on site for 8-10 hours per week and is also on-call. Roster shortages or sickness are covered by casual or off duty staff. The caregivers, residents and family member interviewed report that there is sufficient staff cover.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Prior to entry to the service residents are assessed by an agency; Options Hawkes Bay. The referral is used as a baseline for the initial support plan that is developed within 24 hours of admission. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Residents’ files are integrated and include allied health professional, specialist and GP input and reviews. Resident files are stored securely and protected from unauthorised access. Records can be accessed only by relevant personnel. All resident files are hard copy.  |
| 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 | There is a policy in place that includes resident admissions (link to 1.2.3.3 as this policy is not comprehensive). Needs assessments are required prior to entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. There is an information pack provided to all residents and their families on services available. Residents and or family/whānau are provided with associated information (eg, information on their rights, the Code, complaints management, advocacy, and the admission agreement). The family member and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. The current version of the admission agreement aligns with the expectations in the aged residential care agreement and includes exclusions from the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There are guidelines for death, discharge, transfer and follow-up. When transferring, all relevant information is documented and transferred with the resident. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification for resident transfers.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident’s medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of ‘as needed’ medicines. Short life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three monthly. Not all medication administered was documented on the medication charts and the medication charts were not always signed each time a medicine was administered by staff. One caregiver was observed administering an ‘as needed’ medication without consulting the medication chart, however, the medicines administration round at lunchtime was witnessed and conducted correctly. One resident self-administers medicines. Staff check each shift that the resident has safely self-administered their medications and records this on the medication administration sheet. The GP has not reviewed this self-administration competency three monthly. Residents/relatives interviewed stated they are kept well informed of any changes to their medications. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All food is prepared and cooked on-site by the caregivers who are assigned to cooking duties on the roster. Baking and some food preparation is done by the night staff. There is a four weekly menu in use that has been reviewed by a dietitian annually. The main meal is at midday. The resident likes and dislikes are documented and known to the caregivers. Residents have a food preferences/likes and dislikes form completed on admission. Alternatives are offered. Special diets are accommodated. Care staff have completed safe food handling training. High calorie diets and supplements are offered for residents with weight loss, if needed. Lip plates and smaller serving plates are available to promote independence at meal times. The kitchen is well equipped with gas hobs, electric oven, freezers, one fridge/freezer and dishwasher. All perishable goods are date labelled. Fridge/freezer temperature monitoring and hot food temperature monitoring is occurring. Chemicals are stored in a lockable cupboard. Food is procured from local commercial suppliers and the supermarket. Residents spoke positively about the meals and home baking. Resident meetings provide an opportunity for resident feedback on the meals.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service would record the reason (no bed availability or unable to meet the assessed level of care) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry was declined.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility has embedded the InterRAI assessment protocols within its current documentation. InterRAI initial assessments and paper-based assessments were evident in printed format in all files. All resident files included an up-to-date InterRAI assessment and all had a full suite of paper-based assessments. InterRAI assessments were reflected into care plans, with the exception of behaviour interventions (link 1.3.5.2) and activities interventions (link 1.3.7.1).Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | The resident files reviewed were integrated, and promoted continuity of service delivery. The GP, allied services, the RNs, activity staff, physiotherapist and other visiting health providers write their care notes in the resident file. The service uses a care plan template that was individualised, however interventions for challenging behaviour were not well documented. Two resident files for residents with mental health needs had documented interventions from the mental health for older services team. The care plans reviewed described the resident needs and care interventions required to support the resident’s independence and wellbeing. Care plans are available to guide caregivers. Caregivers interviewed were knowledgeable regarding individual resident cares. There were short-term care plans in use for short-term needs and changes in health status. There is documented evidence of resident/family input into care planning and six monthly reviews.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | All resident files reviewed had care plans in place. Residents interviewed reported their needs were being met. A family member interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.Documentation was reviewed for two wounds - one skin tear, and one chronic wound. There were no pressure injuries. The evaluation of wounds was not comprehensive.Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | There is one activities coordinator employed, a non-practicing RN, who is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. The activities coordinator is employed three days a week. Caregivers assist with individual and group activities programmes at other times during the week and at weekends. Each newly admitted resident has an individual activities assessment and a social assessment completed and an individual activities plan is developed, however the individual activities plans do not always align to the activities assessment and the InterRAI assessment. The individual activities plan is reviewed six monthly when the resident’s care is reviewed. A weekly plan is developed and is displayed in the main lounge, which may change as necessary. Residents have the opportunity to provide feedback and suggestions for future activities, outings and entertainment. The programme is flexible and accommodates community visitors and groups. Residents are supported to attend their own church and are transported by families. A wheelchair taxi is hired at least weekly or more for outings. Special events and festive occasions are celebrated. On the day of the audit, residents were observed being actively involved with a variety of activities including external entertainers. The group programme includes residents being involved within the community with social clubs, churches and schools. A record is kept of individual resident’s activities and monthly progress notes completed.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents and their care plans are evaluated using the InterRAI process at least six monthly or if there has been a significant change in their health status. The RN also documents a weekly review of the resident’s care provided and outcomes.The GP reviews residents three monthly or when requested if issues arise or their health status changes. The GP was interviewed and stated that the staff communicate appropriately. Short-term care plans were evident for the care and treatment of residents. Short-term care plans are typically used for residents with infections and those who have significant changes in their medicines management regime. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to medical and non-medical services. The registered nurse interviewed confirms that residents, family and the resident’s GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the registered nurse. A relative and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is a waste and hazardous substance safety policy. Management of waste and hazardous substances are covered during orientation of new staff and as scheduled on the education planner. All chemicals sighted were labelled correctly and were stored in locked areas. Safety datasheets are available. Gloves, aprons, goggles and shoe covers are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness, which expires 17 January 2017. Two of the double bedrooms are currently occupied by one resident only. The building has internal and external ramps on the ground floor. There is a planned and a reactive maintenance programme in place. There is a communication book used for the daily maintenance requests. The manager coordinates and authorizes the contractors to carryout maintenance requests. Corrective actions are documented in the communication book. The manager is available on call for urgent matters. Electrical equipment not hard wired has been tested and tagged annually. Hot water temperature monitoring is completed monthly with readings within acceptable ranges. There is storage for equipment and supplies although space is limited. The interior of the home is well maintained and homely. There is an open plan combined dining area/lounge area and a second lounge area available. Residents were observed to be moving freely around the facility with the use of mobility aids. There is outdoor seating and shading in place. The grounds are well maintained. There is a safety gate across the driveway with plenty of street parking.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | No resident bedrooms have hand basins or ensuite bathrooms. There are four resident communal toilets and a separate toilet for staff and visitors. There are three showers for residents. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. There are privacy locks on the doors on the showers and toilets. Residents interviewed confirmed staff provide the resident with privacy when attending to personal hygiene cares.  |
| 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 | The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is easy access to the communal areas. The dining area and main lounge area is open plan where activities take place. There is a second large lounge at the front of the building where residents can have visitors or spend time with quiet activities. Communal areas are accessible. There is adequate space to allow for individual and group activities to occur within the lounge.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Caregivers undertake the cleaning and laundry. Laundry procedures and cleaning duties are documented. There is a commercial washer and a commercial drier and sink in the laundry. Linen is dried outside on the clothesline where possible. The laundry door is latched to prevent resident entry when staff are not in attendance. Chemicals are stored safely in the manufacturer’s containers in the laundry and in other locked areas. Safety datasheets are readily accessible. Protective clothing is available for staff. Chemical training occurs. The effectiveness of the cleaning and laundry service is monitored by the manager through resident and relative feedback, the internal audit programme and resident meetings. Residents interviewed were satisfied with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. A fire evacuation drill is conducted six monthly. There is an approved evacuation plan. There is an emergency and business continuity plan and a pandemic plan and other health and safety policies in place to ensure health, civil defence and other emergencies are included. The facility is well prepared for civil emergencies and carries emergency equipment and supplies in the event of an emergency including PPE. Alternative energy sources are available as the kitchen has electricity and gas. The facility carries emergency lighting, battery backup and spare gas bottles/camp burners. A store of emergency drinkable water is available. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The call bell system is available in all areas and there are indicator panels above each door and in the middle of the facility. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. The facility is secured at night. Residents interviewed stated their call bells were answered in a timely manner. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas are well ventilated. Bedrooms have an external window to allow natural lighting and ventilation. Fans and external doors are used in summer to remove heat from the building. There are oil-filled heaters in the bedrooms and panel heaters in the corridors and communal areas, which are used continually during the winter months. The residents confirmed the temperature of the facility is comfortable.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The infection prevention and control (IPC) programme is appropriate for the size and complexity of the service. The registered nurse is the infection prevention and control officer. The facility has a suite of infection prevention and control policies. The infection prevention and control practices are authorised and reviewed annually by the registered nurse. The infection prevention and control programme results are discussed at the general staff meetings. Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents and staff. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control is managed by the infection control coordinator (registered nurse). The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The RN last completed refresher training in infection prevention and control in May 2015. The orientation package includes specific training around hand washing and standard precautions and training was provided both at orientation and as part of the annual training schedule. A record has been kept of staff attendance.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place and are appropriate to the size and complexity of the facility. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a policy around restraint in place, however there is insufficient enabler definition provided in the restraint policy. Summerville rest home has a restraint free philosophy. On the day of the audit there were no reported events of either restraint of enabler use. There is a policy around restraint in place however, the definitions including enablers was insufficient to meet the current required standards (link 1.2.3.3). Staff education on restraint minimisation and management of challenging behaviour has been provided.  |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.1The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | The service has an overarching quality programme which outlines quality activities. Internal audits are conducted and meetings are held. The service does not have a current annual business/quality plan in place. The managing director was using the prior owner’s annual business/quality plan until it expired at the beginning of January 2016. | The service does not have a current annual business/quality plan for 2016 in place, including annual goals, objectives, action plans, responsibilities and date/timeframes | Ensure that an annual business/quality plan is documented and implemented.90 days |
| Criterion 1.2.3.3The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | There are a range of policies, associated procedures and forms in place however, not all policies and procedures are robust to provide in-depth guidance for staff.  | Policies and procedures reviewed which do not provide in-depth guidance for staff include the abuse/neglect, sexuality/intimacy, spirituality, privacy/dignity, informed consent, cultural safety, open disclosure, admission processes, incident reporting and staffing rationale policies. | Ensure that all policies are reviewed to meet the requirements of the relevant Health and Disability Services Standards 2008.180 days |
| Criterion 1.2.7.4New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Five staff files were reviewed including one manager, two caregivers, one RN and one activities coordinator. Not all staff files reviewed had an employment contract and a signed job description. New staff complete an orientation that was sighted in four of the five files reviewed | i) Five staff files reviewed did not have signed job descriptions; ii) two files did not have employment contracts; and iii) one staff file reviewed did not evidence completed orientation documentation | i) Ensure all staff files evidence a copy of a signed job description; ii) ensure all staff files evidence a signed employment agreement; and iii) ensure that all staff complete the orientation programme documentation90 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. Not all medications are documented on the medication charts and staff do not always follow procedure for the administration of medications. | i) One resident on oxygen (noting that the respiratory clinic notes and the GP notes both refer to the use of oxygen) did not have this charted on the medication chart and one resident on Buscopan as needed, (noting this was prescribed on an earlier medication chart and was being dispensed by the pharmacy) did not have this medication charted on the current medication chart; and ii) a caregiver was observed administering an ‘as needed’ medication without checking the medication chart, or asking the RN for advice or for an RN review of the resident.  | i) Ensure that all medication is prescribed; and ii) ensure that all staff follow the medication policies and procedures, including RN assessment prior to the administration of PRN analgesia.30 days |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There are appropriate polices in place to manage the self-administration of medications. One resident had a competency and assessment in place, however this had not been reviewed by the GP. | One self-administering resident did not have the medication competency reviewed three monthly by the GP.  | Ensure the three monthly GP reviews include the self-medication competency if the resident self-medicates medications.30 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | The service uses a care plan template that is individualised to resident need, InterRAI assessments and risk assessments form the basis of the long-term care plan. Behaviour that challenges did not have all interventions to manage documented.  | Two resident files for residents with behaviour that challenges had the behaviour documented in the care plan but no interventions as to how to manage the behaviour. | Ensure that care plans document all resident needs and required management interventions.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Wound care plans were paper-based and included an assessment, wound management and evaluation forms. Short-term care plans documented regular review.  | The evaluation of wounds did not include information such as size, depth and exudate. | Ensure the evaluation of wounds is comprehensive to allow comparison and to measure improvement.90 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. Some of those included in activities offered are external seniors groups, trips to other homes, pet therapy, daily discussion groups and exercises. Individual resident activity plans were reflective of the resident’s stated needs for three of five resident files reviewed. | For two of the resident files reviewed the activities plan was not reflective of the activities assessment and the InterRAI social needs assessment.  | Ensure that activities plans are individualised to the resident need and relevant assessments.90 days |

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

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

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

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

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End of the report.