# Heritage Lifecare Limited - Maygrove Rest Home

## Introduction

This report records the results of a Partial Provisional Audit; 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](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:** Heritage Lifecare Limited

**Premises audited:** Maygrove Rest Home

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

**Dates of audit:** Start date: 25 November 2016 End date: 25 November 2016

**Proposed changes to current services (if any):** New configuration of a new staff room, one separate shower and toilet facility, four rooms (three single rooms and one designated double room). A lift and nurse call bell system have been installed.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 38

# 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

Maygrove Rest Home is one of a group of facilities owned and operated privately by Heritage Lifecare Limited. The rest home provides rest home level of care for up to 39 residents.

This unannounced surveillance and partial provisional audit was conducted against the Health and Disability Services Standards and the provider`s contract with the district health board. The partial provisional audit was for four additional resident rooms (three single and one double room), one separate bathroom and a staff room added to this facility. An internal lift and nurse call systems are installed.

The audit process included the review of organisational documentation, staff records and residents` clinical records, observations, and interviews with residents, families/whanau, management, staff and a general practitioner.

Feedback from residents and families/whanau was positive about the care and services provided.

There were no corrective actions to follow up from the previous audit however; three areas were identified for improvement one in relation to medication management and two in relation to care evaluation and delivery plans.

## Consumer rights

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| --- | --- | --- |
| 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. |

Residents and family/whanau receive full and frank information which reflects the principles of the open disclosure policy. The resident and their family/whanau are involved in the care planning, decision making and consent processes. Interpreter services are available if required.

The service has a documented complaints management system implemented. There are no outstanding complaints at the time of this audit.

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

The facility manager ensures that the day to day management of all aspects of service delivery is maintained and reports to the operations manager and to the quality and compliance manager as required. The service has business and strategic plans. The business plan has been reviewed. Quality data covers all key components of service delivery and is collected, reported and analysed monthly. Results are shared at all levels of the organisation and corrective planning is put in place as required to make improvement where areas of concern of deficits are found. This allows effective, timely service delivery.

The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint monitoring, and infection prevention and control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whanau, as appropriate.

The facility manager is responsible for the education programme provided to staff and records are maintained. All staff receive appropriate education for the roles they undertake.

Staffing levels ensure residents` care is timely, appropriate and meets assessed needs.

## 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’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty every day, with a registered nurse on call at all other times. Nurses are supported by care staff and general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme, overseen by an activities coordinator, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic medicine management system. Medications are administered by registered nurses and senior care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Detailed policies and processes guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised and meets food safety standards. Residents stated they enjoyed the meals.

## 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. |

The facility has been purpose built. The new configuration has been planned and built as a second level with lift access. Rooms are single with communal showers and toilets in close proximity to resident`s rooms. All rooms are of an adequate size to provide personal care related to the services being provided.

Building and plant complies with legislation and a current building warrant of fitness for the rest home is displayed. A certificate for public use was sighted for the new configuration. A preventative maintenance plan is in place and reactive maintenance occurs.

Communal areas are spacious and maintained at a comfortable temperature. External areas and seating is available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals and equipment are safely and securely stored. Laundry and cleaning services are available on site and cleaning and laundry staff are employed, with systems monitored for effectiveness.

Emergency planning is linked to civil defence and to the district health board. Regular fire drills are completed and the fire evacuation scheme has been updated to include the new configuration and approved by the New Zealand Fire Service. The rest home promotes a safe environment.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process is in place should this be required.

## Infection prevention and control

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

Aged care specific infection surveillance is undertaken, analysed and trended. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 22 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 53 | 0 | 0 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Maygrove Rest Home implements policies and procedures to ensure complaints processes reflect a fair complaints system and complies with Right10 of the Code. During interview residents, family/whanau and staff reported their understanding of the complaints process. Staff confirmed they document verbalised complaints so all issues are accurately reflected and are followed up by the facility manger. All complaints are investigated by the facility manager and documentation is contained in a register which identifies the nature of the complaint, the dates received and the actions taken to address the complaint. Documented complaints information is used to improve service delivery as appropriate. Complaints information is forwarded to the operations manager and quality and compliance manager at head office as part of the monthly reporting and to the DHB for the quality indicators for safe aged care.Complaints forms are available to residents and visitors.There are no outstanding complaints at the time of the audit. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff and management confirm residents` rights to full and frank information. The service implements the open disclosure policy. Family/whanau contact is documented in resident files and confirmed during interview. Family/whanau stated they were kept well informed about any changes to their relative`s health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents` records reviewed. There was also evidence of resident /family input into the care planning process.The service had processes in place to ensure the resident is able to communicate their needs and understand what staff are asking. The facility manager stated that interpreter services could be accessed if required. Staff are fully aware of how to contact approved interpreter services and stated they would use policy guidelines if required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Maygrove Rest Home is one of a group of facilities operated by Heritage Lifecare Limited Management Services Ltd. The facility is supported by a senior management team from the organisation`s head office. The operating systems, including monitoring systems and policies and procedures are centralised across the organisation. The service has a business plan 2016 - 2107 in place which is reviewed annually by the directors and monitored monthly by management to measure progress towards meeting business goals. Site objectives are also developed and implemented to meet the needs of the residents.On the day of the audit the service has 38 residents all of which are rest home level care. The additional scope of the audit is to increase another four rooms one of which is designated as a double room.There is a facility manager in place who is experienced in aged care and has been in the role for two years. The facility manager, a registered nurse, is supported by two other registered nurses all of whom have a current annual practicing certificate. All have undertaken ongoing education related to aged care. The facility manager has completed education related to nursing management. Accountability and responsibilities are clearly described in the job descriptions sighted.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the facility manager’s absence one of the senior registered nurses is responsible for the oversight of services. The registered nurse has worked at this facility for sixteen years and is the designated restraint and health and safety coordinator. The staff would be notified of the facility manager going on authorised leave. |
| 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. | FA | Maygrove Rest Home has a quality and risk system which is understood and implemented by service provides. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and management, restraint management complaints management.If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions are developed and overseen by the facility manager. Quality information is shared with all staff via the handover process on each shift and/or during staff meetings. This is verified during the staff interviews and in documentation reviewed. Reporting is undertaken electronically and management have access to all reports.The policies reviewed reflected legislative and good practice requirements. There is a system in place at head office to ensure they are kept up-to-dateQuality data is trended against previously collected data. An annual review is undertaken. This is linked to the quality and risk management system in place. Day to day analysis of data is monitored by the facility manager and corrective actions are implemented as required.The annual quality review is used to highlight both positive and negative findings. For example there was a reduction in medication errors. Staff, resident and family/whanau interviews confirmed any concerns they have are adequately addressed by management.Actual and potential risks are identified using the quality and risk processes. Any newly found hazards are discussed, monitored and managed via the health and safety processes in place. The senior registered nurse is the rest home health and safety coordinator and the facility manager oversees this process. Staff confirmed that they understand and have implemented documented hazard identification processes. The hazard register sighted is current and up-to-date. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Adverse event reporting as identified in policy is implemented by the service. The facility manager confirmed awareness of the organisation`s requirement related to statutory and/or regulatory obligations including the need to report pressure injuries under section 31 of the Work Place Safety Act 2015. Reporting forms are included in the policy and procedure manual. The general practitioner interviewed confirmed awareness of reporting infection control outbreaks and other notifiable disease to the appropriate health agency required. There have been no outbreaks since the previous audit.Staff interviewed stated that they report and record all incidents and accidents and that this information along with any corrective actions is shared at the staff meetings as confirmed in minutes of meetings sighted.Documentation in residents` files, which includes incident and accident forms identified that all issues reported are addressed and any corrective actions are put in place when required. Information is also entered electronically and the facility manager monitors corrective actions and documents outcomes. The operations manager and the quality and compliance manager are notified immediately of any serious adverse event. Family/whanau/representative notification is clearly shown in documentation and was confirmed during family/whanau interviews. The facility manager reported during interview that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Human resource management processes are conducted in accordance with good employment practices and meet legislative requirements. The organisation appoints the facility manager and the facility manager is responsible for employing appropriate service providers to meet the needs of the residents. Processes are clearly defined in the policies and procedures sighted.Staff records reviewed have job descriptions that describe staff responsibilities and accountabilities. Staff orientation/induction process is completed for all new staff. Documentation in the staff records reviewed confirmed some competencies, such as medication management, fire, first aid and infection prevention and control. Fire and other mandatory training is reviewed annually. A checklist is available in each staff record reviewed. Staff employed and contracted service providers with professional qualifications, have them validated as part of the employment process and on-going on an annual basis. A system is in place for maintaining these records electronically and in hard copy. Employment processes include reference checking, police checking and annual staff appraisals. (All appraisals are up-to-date for the staff records reviewed). The facility manager is a trained assessor for Careerforce training. Staff will be transferring previous New Zealand Qualification Authority (NZQA) aged care training over to this new training programme commencing in 2017.The facility manager and one registered nurses hold current interRAI competencies.The training for 2016 identifies that staff have undertaken training and education related to the roles they undertake. Topics covered in annual training and education relates to an aged care setting and health care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site.Resident and family /whanau members interviewed, identified that the service meets the residents` needs.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented process in policy which determines service provider staffing levels and skill mix. The facility manager confirms the rostered numbers of staff change accordingly to resident acuity and need levels. Staff numbers sighted on the four week rosters show that core staffing is maintained to meet residents` needs and to comply with contractual requirements.Rosters identify that staff are replaced for sickness and annual leave. This was confirmed during the staff and management interviews. Staff interviewed reported they have adequate time to complete all required tasks to meet the residents` needs. There is a registered nurse on all shifts except night duty. Residents and family/whanau members interviewed stated that all their needs have been met in a timely manner.For the re-configuration and partial provisional audit the staff will have minimal changes to cover the four extra bedrooms (three single rooms and one double room) five additional residents in total. The morning shift will be extended by one care staff for two hours a day and the afternoon shift, one care staff will complete a current four to seven shift in the afternoon and this is extended from four to ten o`clock each day of the week. |
| 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 medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic medication management system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and checked off on the medication management system. The majority of medications sighted were within current use-by dates. Refer to criterion 1.3.12. 1. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.The records of temperatures for the medicine fridge reviewed were within the recommended range. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines. The required three monthly GP review of medications is consistently signed-off. There are no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. Medication errors are reported to the facility manager or registered nurse on call, and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Standing orders are not used.  |
| 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 | The food service is provided on site by two very experienced cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was last reviewed by a qualified dietitian on 8 November 2016. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and documented. All kitchen staff have completed relevant food handling training.A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the two dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and they feel comfortable with the standard of care provided to residents. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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. | FA | The activities programme is organised by an activities coordinator who is available for six hours each week day. The facility manager advised that the activities coordinator, who has only been in the role for two months, is about to start training for the National Certificate in Diversional Therapy. A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. An individual plan is developed for each resident, although the goals in the plans reviewed were not detailed. The resident’s activity needs are evaluated six monthly as part of the formal six monthly care plan review, and a detailed analysis is undertaken monthly that documents each resident’s participation in the activities programme, and other relevant comments. Refer to criterion 1.3.8.2. The facility manager advised that a review is about to be undertaken related to better coordinate the processes relating to planning and evaluating residents’ activity goals. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include shopping trips, quizzes and word games, movies, entertainment, shopping trips, gardening, current events and bingo. Residents interviewed confirmed they find the programme enjoyable and varied. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations are not consistently undertaken on a six-monthly basis, but the interRAI reassessment is undertaken six-monthly. Evaluations are documented by the RN but when progress is different from expected, but the service does not consistently respond by initiating changes to the plan of care. Short term care plans are not closed off in a timely manner. Residents interviewed advised they had been involved in the evaluation of their progress.  |
| 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 | Review of documents, visual inspection of the premises and observations of practice on the day of the audit, confirmed that safe and effective waste and hazardous management processes are established. Expectations are documented in policy and procedures are displayed in staff areas. These define all types of waste and describe the techniques for managing these. Staff are informed about procedures during orientation/induction. There have been no significant events related to waste management.Personal protective equipment for use by all staff is readily available in various locations around the rest home. |
| 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 is designed to be fit for purpose as a rest home. There are currently 39 single rooms and 38 are occupied on the day of the audit. The new configuration consists of four individual bedrooms (three single and one double room) a new staff room, three shared bathrooms and one bathroom and toilet in close proximity to all bedrooms. There is access by stairs and a lift is installed for the residents as the new rooms are located upstairs from the rest home which is on one level. The rooms are of an adequate size and provided freedom of movement for residents and for maintaining independence with the use of walking aides. The equipment, plant and chattels are new. All equipment has been tested and added to the inspection schedule sighted. Visual inspection of all internal and external areas shows that the environment is safe, spacious and appropriate for use. The certificate of compliance for the new lift is dated 21 October 2016. The compliance electrical safety certificate for the new build is dated 25 October 2016. A certificate for Public Use is dated 11 November 2016. The building warrant of fitness for the rest home is displayed and the expiry date is 10 June 2017 |
| 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 | The showers and toilets are located in close proximity to the residents` individual rooms. All rooms have a hand basin. There is a visitors’ toilet and a designated staff toilet. Hot water in all areas is monitored to ensure it does not exceed 45 degrees. There have been no untoward incidents related to toilet or shower facilities, which demonstrate that the systems for maintaining privacy and safety for everybody who uses them is effective. The new configuration has toilets in the four room, hand basins and a large separate shower and toilet is available in close proximity to the four individual resident`s rooms. The staff room has a sink for washing dishes and the staff toilet is on the ground floor with a hand basin facility being available.  |
| 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 | Visual inspection revealed that the 39 individual rooms on the ground floor of the rest home are very spacious, and are furnished with beds and residents have the choice of bringing some of their own furniture in from home on admission. Rooms are personalised and there is no restriction to the ability of staff, residents or their family support persons to move around. Residents are able to move freely with walking aids, motorised scooters and/ a wheelchair if needed. The residents and their family members interviewed expressed high satisfaction with the facility.The new configuration of four individual resident`s rooms (three single and one double room) does provide adequate personal space/bed areas appropriate for residents in all designated rooms sighted. |
| 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 | The rest home has two communal dining rooms in close proximity to the kitchen. These are comfortably furnished and appropriate for the needs of the residents. Residents and their families who were observed to be using these areas commented favourably about them. There is a large lounge available for residents to sit and watch television and to participate in the activities programme, and another lounge is located near reception. |
| 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 | The cleaning and laundry is done onsite at this facility. There is a designated laundry. The laundry person works Monday to Friday 9am to 1pm four hours a day. There are two commercial washing machines and adequate dryers for the volume of laundry. Cleaning is completed seven days a week 8.30am to 2pm five hours a day. The cleaner uses a cleaning trolley which is stored in a locked room when not in use. The facility manager is responsible for ordering all supplies for these two services. Chemicals are stored securely and appropriately in a locked shed. All containers are labelled correctly and a refillable system is in place in the sluice room and laundry.Audits are performed as part of the internal audit schedule and evidenced in the quality reports sighted. Material data sheets are available and accessible to staff on all products utilised. Staff interviewed have a good understanding of reporting any hazards to the facility manager. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | All staff have first aid certificates as evidenced in the staff files reviewed. A first aid kit is available in the rest home van and in the treatment room. A staff member with a first aid certificate is on duty each shift. The staff are trained for civil defence emergencies. The New Zealand Fire Service has approved the fire evacuation scheme on the 24 August 2016 for the new build. Documents reviewed and staff interviews confirm that regular fire drills are occurring. The last recorded was 30 September 2016. These are completed six monthly as required. All staff are inducted to emergency procedures, equipment and guidelines and are regularly tested on their knowledge.The staff on afternoon and night duty perform regular checks of the building and surrounding areas. The New Zealand Police would be called if any security breach occurs.A nurse call system is available in each resident`s room, bathrooms, toilets and all service areas. There is a call bell system for the new rooms and a call bell is available in all five bed spaces and the toilet of each room. The separate shower/toilet has a call bell in place. A locator board is available upstairs on the second level and on the ground floor.Emergency resources are available for a civil emergency or for an infection pandemic situation. All resources were reviewed in September 2016 by civil defence and the service is now connected by phone directly to this service and to the DHB. Tsunami planning is in place due to the locality of the shoreline for this facility. A disaster kit is available with additional emergency food. Gas cooking and water is available. Two litres of water per resident is stored and changed regularly. An external water supply is available for washing and cleaning from an outside water tank. Emergency power in the form of a generator is readily available. |
| 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 | The site inspection revealed that the building is heated with electric heaters. Heat pumps and wall heaters are available in the hallways and individual resident`s rooms. Additional heaters are used in the cooler months if needed in the main lounge. Residents and family interviewed confirmed that temperatures in the building were comfortable at all times. All rooms have openable windows for ventilation and provision of natural light.The new rooms each has external windows that open out and electric heaters are fixed to the walls. |
| 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 | Well-established and comprehensive systems are in place to monitor infections. Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, eyes, gastro-intestinal and respiratory tract. When an infection is identified, a record of this is documented in the group’s electronic resident management system. The facility manager reviews all reported infections. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Reports are generated by the organisation which provides a monthly evaluation against other facilities within the group. The facility manager advised that external benchmarking will be commencing in 2017.The facility manager advised that surveillance results are reported at the facility staff meeting, which incorporates the monthly quality meeting, as well as discussing any required corrective actions. This was confirmed in meeting minutes, and in interviews with staff. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. The policy contains all necessary processes related to the safe use of restraint. The service had no restraints or enablers in use at the time of audit. A senior registered nurse advised that restraints had not been used in the facility for a number of years. Clinical staff undertake annual restraint minimisation education. Staff verbalised their knowledge and understanding of safe restraint use. |

# 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 1.3.12.1A 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 | With the exception of replacing medications once they are past their expiry date, all aspects of medication management are consistent with best practice and legislative requirements. In the medication trolley, five glyceryl trinitrate sprays were past their expiry date, as were three blister packs of pro re nata (as required) medications. The facility manager advised later during the audit visits that all these expired medications had been reordered, and that a system had been developed to ensure that medications were checked regularly to ensure they were within use-by dates. | Medications are not replaced when past their expiry date.  | All medications are within use-by dates. 90 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | In the six clinical records reviewed, evaluations of service delivery plans were generally detailed, and reflected a careful review of resident progress towards meeting identified goals. Evaluations of service delivery plans, including activity goals, were not completed within the required six-month timeframe in three of these files. Four short term care plans had been appropriately developed in relation to acute care needs, but had not been evaluated or signed off. Six residents had current wounds, and the documentation related to these was reviewed. Although these wounds had been assessed initially, and there were records of wound dressings changes recorded on the soft tissue care plan, the status of five of the six wounds was unclear in relation to wound size, depth and healing status. The Facility Manager advised that a project is underway to review all clinical forms, including wound documentation. | Evaluations are not consistently completed within required timeframes and/or do not record progress towards meeting desired outcomes. | Evaluations that record progress towards meeting desired outcomes are completed within requirement timeframes. 90 days |
| Criterion 1.3.8.3Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Formal care plan evaluations generally occur on a six monthly basis, and the interRAI reassessment is undertaken six-monthly. Evaluations are documented by the RN but when progress is different from expected, the service does not consistently respond by initiating changes to the plan of care. Short term care plans are not closed off in a timely manner. Residents interviewed advised they had been involved in the evaluation of their progress.  | When progress is differs from planned goals, service delivery plans are not updated. | Service delivery plans are updated when resident progress differs from planned outcomes. 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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| No data to display |

End of the report.