# Experion Care NZ Limited - Greendale Residential Care Centre

## Introduction

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

The audit has been conducted by Health Audit (NZ) 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:** Experion Care NZ Limited

**Premises audited:** Greendale Residential Care

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

**Dates of audit:** Start date: 8 November 2016 End date: 8 November 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:** 24

# 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

Greendale Residential Care Centre provides residential care for up to 27 residents who require rest home level care. On the day of audit there were 24 beds occupied. The facility is operated by Experian Care NZ Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Systems have not been maintained since the previous provisional audit and some key documents were not available for review during this audit.

Areas requiring improvement from the previous audit relating to currency of first aid certificates, and annual review of the infection control programme have been addressed. The medication fridge temperatures not being monitored and recording of medicine reviews remain open.

Areas requiring improvement from this audit relate to: the manager’s hours; notification of a new manager to the Ministry of Health; the internal audit programme not followed; the briefness of meeting minutes; analysis of quality data; the management of complaints; corrective action plans; reporting of essential notifications; human resource management; ongoing education; competency assessments; care plan interventions; provision of activities; administration and competency of medication management; menu not dietitian approved and food storage.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Information regarding residents’ rights, access to interpreter services and how to lodge a complaint was available to residents and their families. Residents and their families reported their satisfaction with open communication with staff.

The nurse manager advised there have been no investigations by the Health and Disability Commissioner or other external agencies since the previous 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Experian Care NZ Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management plan include a documented vision, mission statement, scope, goals, principles and overall aims. There are systems in place for monitoring the service. The nurse manager reports to the owner/director via a daily phone call.

The facility is managed by an experienced nurse manager who also manages another facility within the area. The nurse manager is supported by an enrolled nurse/assistant manager.

There is an internal audit programme and an up to date hazard register. Adverse events are documented on accident/incident forms. Accident/incident forms and audits evidenced corrective action plans are developed and implemented. Staff, resident and relative meetings are held on a regular basis.

The risk register evidenced review and updating of risks and the addition of new risks. The health and safety representative has attended training in the Health and Safety at Work Act (2015) requirements.

There are policies and procedures on human resources management. Staff have the required qualifications. An in-service education programme was sighted.

The documented rationale for determining staffing levels and skill mixes is based on best practise. The enrolled nurse/assistant manager and nurse manager are on call after hours.

## 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. |

On admission residents’ needs are assessed by the enrolled nurse with oversight from the registered nurse, within the required timeframes. 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. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, provides residents with individual and group activities. A facility van is available for outings.

Medicines management is guided by policies and procedures based on current good practice and implemented using a manual system. Medications are administered by care staff whom have been assessed as competent to do so.

The kitchen was well organised, clean and meets food safety standards.

## 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. |

A current building warrant of fitness is displayed. There have been no structural alterations to the building since the previous audit.

## 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.

## 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 and results 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 | 8 | 0 | 2 | 7 | 0 | 0 |
| **Criteria** | 0 | 23 | 0 | 6 | 10 | 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. | PA Moderate | The complaints policy and associated forms meet the requirements of Right 10 of the Code of Rights. The information is provided to residents and families on admission and there is complaints information and forms available within the facility.  The nurse manager (NM) is responsible for complaints management and follow up and reported there have been no complaints since the previous audit. The complaints register showed no complaints have been received over the past year. Review of documentation evidenced there have been complaints made since the previous audit. These have not been entered in to the register and there was no documentation evidenced relating to the complaints.  Staff interviewed had a good understanding of the complaint process and what actions are required.  The nurse manager reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, DHB, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents’ records included evidence of open disclosure and timely communication with residents/families. Family members stated they were informed in a timely manner about any changes to the resident’s status and appreciated the ongoing communication with staff. Evidence was sighted of both families, and where possible, residents, having input into the care planning process. Staff were observed communicating effectively with residents and family members. The nurse manager advised interpreter services can be accessed from the local district health board when required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate | Experian Care NZ Limited is the governing body and is responsible for the service provided at Greendale Residential Centre (Greendale). There are two directors of the company, one resides overseas and the other is the nurse manager who reported they have no financial investment in the company and is a director on paper only.  A business plan and a quality and risk management plan were reviewed and include a vision, a mission statement, goals, principles, overall aims and scope of service. The service philosophy is in an understandable form and available to residents and their family / representative or other services involved in referring people to the service.  Significant documentation prior to March 2016 was missing from files. The nurse manager and enrolled nurse/assistant manager (EN/AM) stated they do not know where the documents have gone to and this was the situation when they were first employed.  Meeting minutes reviewed evidenced that monthly staff meetings including: quality; health and safety; infection control and restraint and resident’s meetings are held four to six monthly. Meeting minutes are available for review by staff. The NM stated they provide daily updates to the owner/director in via phone. Updates include occupancy, staffing, new residents and financial matters. The owner/director visits the facility approximately every four months.  The facility is managed by an experienced nurse manager who is a registered nurse and has been in the role since March 2016 replacing the house manager whose position was made redundant. The nurse manager is also the manager at another facility in the area that is owned by the same company. The nurse manager has also experience in managing other facilities. The NM stated they work full time and spend around 15 hours a week at Greendale. Interviews of the managers and staff showed the NM is unable to fulfil their responsibilities of nurse manager and of the main registered nurse. The NM reported that because of the hours allocated they are taking work home including interRAI assessments. The NM stated they have handed in their resignation and leave both facilities at the end of December. The NM also stated the owner/director is currently advertising the two positions. The NM is supported by a full time EN/AM who has been in their role since May 2016. A registered nurse (RN) is also employed to work four hours per week. The EN/AM reported that four hours per week of RN input is not enough time to be effective.  Greendale is certified to provide rest home level care. On the day of this audit there were 21 rest home residents including one resident under 65 years of age. There were also three mental health respite residents under the age of 65 years of age.  Greendale has contracts with the DHB to provide aged related residential care, mental health residential care, long term support-chronic health conditions, and respite and day care services. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | The quality and risk management plan is used to guide the quality programme and includes quality goals and principles. There was evidence that quality improvement data is collected and collated. There was no evidence of analysis of data apart from numbers for each month. Corrective actions are developed and implemented to improve service delivery for internal audits and incident/accidents, however, corrective action plans are not developed and implemented flowing deficits identified in meeting minutes. There is an internal audit programme for 2016, however this has not been followed and audits for the period January to June were completed in July. The file for the 2015 audits is missing and the managers reported they had no knowledge of where it was. The NM stated the satisfaction survey has been sent out to family members and residents for this year. Previous surveys were not located on site.  Meeting minutes evidenced numbers only of clinical indicators are reported back to staff. Staff stated they are told about the numbers of falls, skin tears medicine errors and infections at their staff meetings. Staff also stated they used to see graphs of clinical indicators, but they are no longer provided.  An aged care consultant provides the current system, including policies and procedures and is responsible for reviewing policies and procedures and provides updates to the facility. They reflect current accepted good practice and reference legislative requirements. Care staff confirmed the policies and procedures provide appropriate guidance and that they are advised of new policies / revised policies. The interRAI policy and procedure reviewed is comprehensive.  A hazard register identifies health and safety risks as well as risks associated with: human resources management; legislative compliance; contractual risks and clinical risks. A health and safety manual includes relevant policies and procedures and a hazard flow chart to guide staff through the process. The NM is the health and safety representative and they have attended education relating to the new health and safety legislation. |
| 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. | PA Low | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. These are collated by the EN/AM. Data includes numbers of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.  The managers and staff stated they are made aware of their essential notification responsibilities through policies and procedures. Review of policies confirmed this. The NM advised they have not had any cause to notify any essential notifications (Section 31) to the Ministry of Health since the previous audit. Review of incident/accident reports evidenced police were involved in an incident two months ago. The NM stated they didn’t know they had to report events involving the police. The NM also advised that the Ministry of Health has not been notified that Greendale had a change of manager in March 2016. |
| 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 Moderate | Policies and procedures relating to human resource management are in place. Staff files evidenced new employment agreements including job descriptions that outline accountability, responsibilities and authority. Apart from one file reviewed of a new employee, documentation relating to applications, orientations, reference checks, education, police vetting and performance appraisals are missing off the staff files. The EN/AM reported they have completed several performance appraisals for this year, however, these were not on the staff files and could not be located. The NM reported their file is with the owner/director and apart from sighting the NM practicing certificate, there was no other documents available.  The education programme for 2016 was developed a week ago and was reviewed. Education records for staff prior to March 2016 were not available. Ongoing education has not been provided for staff until May when the EN/AM commenced employment. Monthly sessions have been provided since then. Education records for these sessions were sighted. Due to the lack of education records and programmes, the auditor could not evidence what education had been provided prior to May 2016 and whether core requirements have been met. There was no evidence of current competency assessments for restraint. There are three residents under the age of 65 years with mental health issues, residing in Greendale and staff have not received any education relating to managing residents with mental health. The mental health team from the DHB have regular contact with the facility, however, care staff expressed concern over how to care for these residents should there be an event.  An orientation/induction programme is available and all new staff are required to complete this. Orientation for staff covers the essential components of the service provided.  Annual practising certificates are current for all staff and contractors who require them to practice.  Care staff confirmed they have completed an orientation. Care staff also confirmed education sessions have restarted and their attendance at on-going in-service education One staff member stated they had recently completed their performance appraisal.  The nurse manager is the interRAI trained staff member and although the interRAI assessments are current, the NM reported they are completing these in their own time at home. The NM reported it is not possible to manage Greendale and complete interRAIs in the hours allocated. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift with one care staff on duty and one on call who lives close by. The nurse manager is also on call as needed. Care staff interviewed reported there was adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover was provided.  There is at least one staff member on each shift with a current first aid certificate, including staff who are on night shift. This finding from the previous audit has been addressed. |
| 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 is current and identifies all aspects of medicine management in line with the regulations, guidelines and best practise.  The staff observed administering medicines did not demonstrate good knowledge and clear understanding of the roles and responsibilities related to each stage of medicine management. All staff who administer medicines are assessed as competent to perform the function they manage (link to 1.2.7.5).  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 prescriptions. All medications sighted were within current use by dates. 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 does not provide evidence of weekly and six monthly stock checks, and this is verified by interview. Standing orders are not used. Standing orders are not used.  The records of temperatures for the medicine fridge in the medication room reviewed were not recorded. Not all medicine reviews are recorded on the medication charts. These This was a finding at the previous audit and remains open. These were findings at the previous audit and remain open.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines. All requirements for pro re nata (PRN) medicines are met. The required three monthly GP review is consistently recorded on the medicine chart, in six of the twelve charts reviewed.  There were no residents who self-administer medications at the time of audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | The food service is provided on site. A varied menu guides the provision of the food service, however the menu has not been reviewed to verify it is in line with recognised nutritional guidelines for older people.  All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, however there is no use by dates on containers of decanted items. Food temperatures, including for high risk items, are monitored appropriately and recorded. The cook has undertaken a safe food handling qualification and is in the process of updating that qualification.  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, however resident meeting minutes’ express some dissatisfaction (refer 1.2.3.8) 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 dining room 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. | PA Moderate | Documentation, observations and interviews verified the provision of care provided to residents was consistent with meeting the residents’ day to day needs and goals, however attention to meeting a diverse range of resident’s individualised needs was not 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 care is satisfactory. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources is available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | An activity coordinator plans and implements the residents’ activities programme which provides for two hours of activities a day, Monday to Friday.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments for residents are regularly reviewed to help formulate an activities programme. The resident’s activity needs are evaluated as part of the formal six monthly care plan review.  The planned monthly activities programme, provides one activity per day which match very few of the skills, likes, dislikes and interests identified in assessment data. Activities are not consistently reflective of residents’ goals, ages (some under 65s), abilities, and ordinary patterns of life and normal community activities. Individual, group activities and regular events are offered, however this is restricted by the two-hour time frame. The activities programme is not evidenced to be discussed at the six-monthly residents’ meetings. Residents interviewed confirmed they find the programme limited. Interview with the activities coordinator verifies the programme is limited by operational constraints. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the EN or the RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the EN and overseen by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short term care plans being reviewed and progress evaluated as clinically indicated. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness displayed. There have been no structural alterations to the building since the previous audit. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. The infection control programme is reviewed annually. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is 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, fungal, eye, gastro-intestinal, the upper and lower respiratory tract, influenza and scabies. When an infection is identified, a record of this is documented. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and their role and responsibilities.  On the day of audit, no residents were using restraints and no residents were using enablers. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Moderate | The complaints policy and processes complies with Right 10 of the Code. The complaints process is explained as part of the admission process and is included in the information given to new residents and family members. Complaints management is included in new staff orientation.  Family members confirmed that they can discuss concerns at any time with staff. Staff had a good understanding of the complaint process and their responsibilities.  Although the NM stated there have been no complaints since the previous audit, review of a staff file evidenced two complaints made by residents. Apart from a letter inviting the staff member to a meeting there was no other documentation relating to the complaints for review. Documentation was not evidenced. | The NM stated there have been no complaints since the previous audit. Review of staff files evidenced a letter inviting a staff member to a meeting relating to two complaints. There was no other documentation relating to the complaints for review. The NM stated they had the documentation, however, this was not made available for review. | Provide documented evidence that all complaints are documented and meet with Right 10 of the Code.  90 days |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The nurse manager reported there have been no complaints since the previous audit and review of the complaints register reflected this. Review of a staff file evidenced there have been complaints made since the previous audit. These were not entered in to the register. | Although there have been complaints made since the last audit, the complaints register has not been maintained and is not up to date. | Ensure the complaints register is maintained and kept up to date.  180 days |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Moderate | Greendale is managed by an experienced nurse manager who is also the manager at another rest home in the area owned by the same company. The NM reported they work approximately 15 hours per week at Greendale. The NM stated they find it extremely difficult to carry out the responsibilities of manager in the hours allocated. The NM stated they take work home at night and this includes completing residents’ interRAI assessments. The NM has completed at least eight hours of on-going education this year. | The NM is dividing their time between Greendale and another rest home owned by the same company. The NM stated the allocated time per week to manage Greendale is not enough time to carry out their responsibilities as manager. | Provide documented evidence that appropriate hours are allocated for the position of manager of Greendale so that they are able to fulfil their responsibilities as manager.  30 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | A quality and risk management plan guides the quality programme and includes goals, principles and overall aim. Staff interviewed including the managers and care staff demonstrated an understanding of the quality and risk management systems. The annual satisfaction survey has been sent out for residents and family members to complete. The internal audit programme for 2016 evidenced the programme has been followed since July 2016. The scheduled audits for January to June 2016 were completed in July 2016.  Staff and resident meetings are held on a regular basis, however, the minutes, especially the staff meeting minutes are brief and lack detail. The minutes do not record who, in terms of residents and staff attended the meetings. | (i)The internal audit programme for 2016 has not been followed. Audits scheduled for January to June 2016 were completed in July 2016. (ii) Meeting minutes, especially the staff meeting minutes are brief and lack detail and do not record the attendees. | Provide documented evidence that (i) the internal audit programme is followed and (ii) meeting minutes are comprehensive and record the attendees.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data is being collected and collated. Staff interviews and review of meeting minutes evidenced numbers of clinical indicators are reported to staff. There is no evidence of analysis of data to identify any trends and staff reported the graphing of clinical indicators is no longer provided. | Quality improvement data is not being analysed to identify trends and reported back to staff. | Provide documented evidence that quality data is being analysed to identify trends and results reported back to staff.  180 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Corrective action plans are being developed and implemented following internal audits, however, there is no evidence of review to show the corrective action has been effective. There is no evidence of corrective action plans following deficits identified in staff and resident meeting minutes. | (i)Corrective action plans are not being developed because of deficits identified in staff and resident meetings. (ii)Where corrective actions have been implemented from internal audits and incident/accident reports, there was no review to evidence effectiveness. | (i)Provide documented evidence that corrective action plans are developed, implemented and (ii) reviewed for effectiveness following all deficits identified.  90 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | Management and staff reported they understood their responsibilities relating to notifying essential notifications to the correct authority. The NM stated there have been no essential notifications needed to be made since the previous audit. Review of incident/accident reports evidenced police were contacted following a resident missing from the facility on the 5 September 2016 and were responsible for bringing the resident back to the facility. The NM also reported the change of manager has not been notified to the Ministry of Health. | (i)The Ministry of Health was not notified (Section 31) of a resident missing from the facility where there was police involvement. The NM stated they did not know they had to notify this to the Ministry of Health. (ii)The change of manager has also not been notified. | Notify the Ministry of Health of this event; (ii) provide documented evidence that the managers and care staff are educated as to what events constitute an essential notification to appropriate authorities and (iii) notify the Ministry of health that there has been a change of manager.  180 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | Apart from recent employees, all staff files have had documentation removed prior to the nurse manager commencing employment, including reference checks, orientation, police vetting, and performance appraisals. The EN/AM stated they had completed several performance appraisals, however, these were not on the staff files and the EN/AM was unable to locate them. The seven staff files reviewed had new employment agreements including a job description and a current medication competency recently completed. Apart from a current practising certificate, the nurse manager reported their file was with the owner/director off shore. | Six of the seven staff files reviewed had documentation missing off the files. Reference checks, police vetting, and performance appraisals were not evidenced. The nurse manager reported their file is with the owner/director of the company. | (i)Provide written information in the staff files of what documents are missing and will now be difficult to obtain. (ii)Provide evidence of police vetting and current performance appraisals. (iii)Provide evidence of human resource documentation for the nurse manager.  90 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | The file for a new employee evidenced an orientation had been completed. Staff interviewed confirmed they had completed an orientation. Orientation documents are missing from the files of those staff who are not recent employees. The nurse manager reported they do not know what has happened to them. | Six of the seven staff files reviewed do not have orientation documents available. | Provide evidence that all staff have completed a re -orientation that is documented and filed.  180 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | An in-service education programme for 2016 was reviewed. The programme was developed a week ago by the EN/AM. The education programmes for previous years and all staff education records are missing which meant evidencing staff education was difficult and staff interviewed were vague as to what education they had attended in 2015. There have been no education sessions this year until May when the EN/AM commenced employment. Education this year has included emergency calls, incontinence product management, pressure injury, privacy and informed consent and abuse and neglect and fire safety. Attendance records for these sessions were sighted. Recent competency assessments for medicines were evidenced, however, staff observed administering medicines did not demonstrate they are competent to do so. (link to 1.3.12.3). Restraint competencies have not been completed. There has been no education provided relating to the three residents with mental health issues currently residing in Greendale. Care staff stated they are concerned about how to manage these residents should there be an event. The NM is the interRAI assessor for the facility and reported they are completing the assessments away from the facility at night because of time constraints. | (i)an in-service programme for 2016 was developed last week, (ii)the previous education programmes and staff records are missing and staff couldn’t remember what they had attended in previous years. (iii)in-service education had not been provided until May 2016, (iv) education relating to mental health has not been provided for staff who are caring for the three residents with mental health issues, (v) The NM is completing residents’ interRAI assessments at home because there is inadequate time to complete these during the hours allocated, (vi) no evidence of restraint competencies. | Provide documented evidence that (i) the education programme is implemented; (ii) record in the staff files information relating to the lack of education; (iii) education is provided relating to managing residents with mental health challenges; (iv) the NM is allocated appropriate hours to complete interRAI assessments on site or an RN is employed that is interRAI trained to take responsibility for completing these and (v) Restraint competencies are current for all clinical staff.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | An allocated refrigerator is available for storing medications however no documentation is available to verify the refrigerator is functioning at the required temperature.  The controlled drug register evidences two nurses signing out controlled drugs when they are administered however there is no evidence of weekly or six monthly stock checks.  The three-monthly medication reviews are recorded on six of the twelve medication charts reviewed. | The medicine management system is not compliant with legislation and medicine management guidelines. | The medicine management system is required to be compliant with legislative and safe medicine management guidelines.  90 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Staff members who administer medication are deemed competent to do so. A staff member observed administering medications had been deemed competent, however observation and interview verified lack of training and understanding around safe medication management, including the administration of insulin. | A staff member deemed competent in medication management lacked understanding around safe medication management when observed and interviewed. The NM stated the staff member concerned will be overseen while administering medications until competency is assured. | Ensure staff who are administering medications are competent to do so.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | A varied menu was sighted though no evidence is available to verify a dietitian has reviewed the menu to ensure it meets recognised nutritional guidelines for older people. Interview with the nurse manager supports this finding, however emails evidence a review is in the process of occurring. | Evidence does not exist to support the nutritional needs of the residents are in line with recognised nutritional guidelines. | The menu is in line with nutritional guidelines for older people  180 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. However, food items that have been decanted have no record of “use by dates” recorded on the container. Some items sighted are past their use by dates. | Food storage is not in line with current guidelines. | Ensure items in use remain within their use by dates.  180 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Resident’s day to day goals and needs were documented in the care plans and staff confirmed they provide care according to the resident’s care plans. The documented interventions, specifically relating to the nursing management of resident’s medical conditions in four of six care plans reviewed, did not always describe the required support needed to meet the resident’s assessed needs. | Interventions are not always consistent with meeting residents’ assessed needs. | Provide documented evidence that interventions are consistent with meeting residents’ assessed needs.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | The activities programme provides activities two hours per day and is not consistent with the activity requirements of the residents’ needs, age, interests and abilities. The activities coordinator reported because of the hours allocated to for activities, it is not possible to provide a varied and stimulating programme. Residents confirmed the activities programme is limited. | Planned activities which are meaningful to the residents, develop and maintain residents’ strengths, skills, and resources are not provided. | Activities are to be provided that are meaningful to the residents.  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.