# Orewa Beach View Retirement Home & Hospital Limited - Orewa Beach View Retirement Home & Hospital

## Introduction

This report records the results of a Provisional 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:** Orewa Beach View Retirement Home & Hospital Limited

**Premises audited:** Orewa Beach View Retirement Home & Hospital

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

**Dates of audit:** Start date: 27 March 2017 End date: 28 March 2017

**Proposed changes to current services (if any):** This facility is having a provisional audit undertaken to establish the prospective owner’s preparedness to provide health and disability services and the current level of conformity with the required standards.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 21

# 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.

## General overview of the audit

Orewa Beachview Retirement Home and Hospital (known as Orewa Secure Care) provides rest home and hospital level care for up to 30 residents, with 15 rest home care beds being in a secure dementia care unit. The service is operated privately by one owner/director and managed by a facility manager with assistance from a clinical nurse manager. Staff in both these roles were appointed in November 2016. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board to establish the prospective owner’s preparedness to provide a health and disability service and the current level of conformity with the required standards for the level of care offered.

The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management, staff, a general practitioner, portfolio manager, current provider and the prospective owners.

This audit has identified areas requiring improvements relating to complaints management, organisational management, strategic planning, quality and risk management, adverse event reporting, human resources management processes, facility specifications, emergency management, evaluation of restraint, recognition of Maori values and beliefs during care planning, assessment processes, and medication management.

## Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The organisation has a documented Maori health care plan developed to support residents who identify as Māori. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident’s needs.

A complaints register is maintained. Two complaints since the previous audit, which went to the District Health Board, have had all improvements completed and were signed off in December 2016. Two complaints are open at the time of audit.

## Organisational management

The service has a business and quality plan in place dated 2015. The organisation’s mission statement, goals and philosophy as currently documented will be continued in the interim by the prospective owners to ensure residents’ needs are met. The prospective owners have developed a transition plan which identifies the new governance structure. The owner/director is a qualified accountant and the second owner has many years’ experience in business management both in New Zealand and off-shore. This will be their first ownership within the New Zealand health industry.

To secure a smooth transition one of the prospective owners will maintain the current systems and procedures with a three-month transition period in which they will be assisted by the existing owner. The prospective owners have a marketing strategy which includes the continuation of trade under the existing name of Orewa Secure Care. One of the intended owners will work at the facility five days a week as a non-clinical manager and be directly involved in the supervision of the organisation and the owner/director will manage the accounts and legal aspects of the business. The transition plan details how this is to be achieved. The clinical operation will remain under the management of facility and clinical nurse managers.

The current documented quality and risk systems and processes will operate but the prospective new owner will introduce their own quality assurance programme over time. The current quality management systems include identification of hazards, staff education and training, an internal audit process, complaints management, and data gathering and reporting of incidents/accidents, restraint and infections.

The human resource policies and procedures documented reflect current good practice. The prospective owners understand verbalised their understanding of human resources management.

The organisation meets contractual requirements related to staff levels. They intend owners intend to continue with the existing rosters and staffing levels and existing staff will be given the opportunity for continued employment.

The resident information system implemented by the organisation meets contractual and legislative requirements.

## Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

Services are provided in an environment that is appropriate to the level of care provided. There are amenities to meet residents’ needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery.

There are adequate numbers of toilets, showers and bathing facilities.

Documentation identifies that processes are maintained to meet the requirements of the building warrant of fitness. Reactive maintenance is documented.

Systems are in place for essential, emergency and security services.

All residents have access to outdoor areas.

The prospective owners identify that planned preventative maintenance measures will be put in place along with reactive maintenance. They are aware of the findings of this audit. There are no plans to make environmental changes to the facility footprint.

## Restraint minimisation and safe practice

The organisation has policies and procedures that support the minimisation of restraint. No enablers and four restraints were in use at the time of audit. A comprehensive pre-assessment is undertaken prior to restraint being implemented. Policy identifies approval and monitoring process to ensure safe restraint use and to meet best practice. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

The infection prevention and control programme, led by a trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

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 | 36 | 0 | 10 | 3 | 1 | 0 |
| **Criteria** | 0 | 83 | 0 | 14 | 3 | 1 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the residents’ record. Staff were observed to gain consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The complaints/concerns issue policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families on admission and those interviewed knew how to do so.  The complaints register reviewed showed that six complaints have been received over the past year. The complaints sighted in the complaints register have actions documented through to an agreed resolution. The last documented complaint and complaints analysis report occurred in August 2016.  There have been two complaints received by the Waitemata District Health Board (WDHB) since the previous audit. One in May 2016 which was referred by the Health and Disability Commission and one in July 2016. Both complaints have been fully investigated by the DHB and were closed off in December 2016 when all corrective actions were implemented.  One complaint of a sensitive nature was reported to the Ministry of Health under Section 31. This has resulted in a police investigation which remains open. One minor complaint received on 23 March 2017 also remains open. Neither of these issues were documented in the complaints register.  The facility manager is responsible for complaints management and follow up. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family/whanau interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussions with staff and the admission agreement. The Code is displayed in the reception area together with information on advocacy services, how to make a complaint and feedback forms. The intended owners interviewed reported that they are aware and acknowledge consumer code of rights and have a good understanding. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room.  Residents are encouraged to maintain their independence by participation in activities of their choosing. Care plans included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | PA Low | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a current Māori health plan developed for residents whom identify as Maori with input from cultural advisers, however the Maori health plan has not been implemented. At the time of audit one resident identified with their Maori culture. Guidance on tikanga best practice is available and is supported by staff. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.  Family/whanau and residents interviewed expressed satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s 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. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. |
| 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 | The strategic and business plan dated February 2015 outlines the direction and goals with policies identifying the purpose, values, scope and direction of the organisation. There are documents which describe objectives and goals. There is no current reporting mechanism up to owner/director level and no monitoring of the organisational objectives is undertaken.  The day to day management of the facility is undertaken by a facility manager (RN) who has been in the role since November 2016 and they are supported by a clinical nurse manager (RN) who commenced work at the facility in July 2016 and moved into the management position in November 2016. Responsibilities and accountabilities are defined in the job descriptions and individual employment agreements. The facility manager does not have an established network for support or guidance in this recently appointed role.  Documentation sighted on the days of audit showed that the service holds contracts with Waitemata District Health Board for Age Related Residential Care (ARRC) and Long Term Support for Chronic Health Conditions - Residential. (Neither the facility manager nor the owner could confirm that the service only holds these two contracts).  One the days of audit all 21 residents were receiving services under the ARRC contract. Twelve residents are receiving care in the secure dementia unit, and nine residents are in the open facility (one at rest home level and eight at hospital level care).  The prospective owner intends to maintain the current structure, with the exception of management, which will be overseen by one of the owners who has had many years’ experience in senior management roles. There are no planned changes within the service. The current owner will be available for support for three months following the sale of the business. There is a proposed new organisational management structure and the takeover date is planned for 1 May 2017. |
| 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. | PA Moderate | There is no process in place to allow the facility manager’s role to be performed if they are absent. During absences of the clinical nurse manager the facility manager who is a RN takes this role. They are experienced in the sector and able to take responsibility for any clinical issues that may arise.  The proposed owners understand their obligation to ensure full staff coverage if a staff member is absent. |
| 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 organisation has a planned quality and risk system. This includes management of complaints, audit activities, a regular patient satisfaction survey, clinical incidents including infections, wound care, restraint and health and safety.  Meeting minutes reviewed confirmed that quality data is reported at staff meetings. Until August 2016 regular review and analysis of quality data was available, but since that time, little or no analysis could be found. Staff reported their involvement in quality and risk management activities through internal audits. There is an annual internal audit calendar in place which has not been kept up to date.  Not all identified issues are addressed by the corrective action process. However, the corrective actions that are documented have been implemented by the service. Resident and family satisfaction surveys are completed annually in August. The results of the survey have yet to be collated. A separate food satisfaction audit, also undertaken in August 2016, identified that residents were happy with all aspects of the service.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice, but they are not all current and no process could be seen to show that they have been reviewed within the last two years. There is no document control system to ensure a systematic and regular review process occur to prevent obsolete or outdated documents being used.  The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There is a risk register in place specific to the facility.  The proposed new owners understand their obligations to produce an annual quality plan and the need to maintain quality management systems which include schedules for internal audits, changes and continuity. One proposed owner will work in the facility to oversee all quality systems. They have may years’ experience related to quality and risk management. Current policies and procedures will be kept in place until the new owners are fully established. They understand the need for all policies and procedures to be kept up to date and ensure all requirements of the Health and Disability Services Standards and legislation are being met. |
| 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 document adverse and near miss events on an accident/incident form. (Refer comment in section 1.2.3.4 related to two different forms being used). A sample of incidents forms reviewed showed these were fully completed and incidents were investigated. There were no corrective action plans generated from any of the incident forms sighted on the days of audit (as discussed in section 1.2.3.8). Serious adverse event data is collated and reported to the Ministry of Health as required. (Section 31 notification sighted). The actions that have been taken to date related to the notifiable adverse event are very clearly documented, however, learnings from the incident are not documented to show how they are used as an opportunity to improve service delivery.  The facility manager and the clinical nurse manager described essential notification reporting requirements, including for pressure injuries. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Staff orientation includes all the basic components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation for orientation is not always completed. Annual performance reviews were not sighted for 2016-2017.  Continuing education is planned on a month by month basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The facility manager is a newly approved assessor for this programme.  Staff working in the dementia care area have either completed or are enrolled in the required education. There are three trained and competent registered nurses who can undertake interRAI assessments. (Refer comments in standard 1.3.3.3). Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place and staff know who to access, when this is needed.  Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Bureau staff are used regularly with an average of five bureau staff being used weekly over the past four weeks. The facility manager stated this was due to staff sickness, resignations and injuries, all of which have been resolved. At least one staff member on duty has a current first aid certificate and there is 24 hour, seven days a week (24//7) RN coverage at the facility.  Rosters show that there are three staff members on night duty. One caregiver is dedicated to dementia care and there is a caregiver and RN in the hospital area.  The proposed new owners do not wish to make any changes to staffing levels at the facility. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes initial interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care hospital facility showed evidence of the yellow envelope system, relevant supporting documentation and ongoing communication with the facility, hospital and family. |
| 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 High | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  Medicine management using an electronic system was observed on the day of audit. All staff who administer medication have completed a medication competency to perform the function they manage, however not all medication administration and disposal of sharps meets best practice  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. 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 and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room 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 and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.  There are no residents who self-administer medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a qualified cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  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 recorded. The cook has undertaken a safe food handling 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. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. 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. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the admission agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | Information is documented using validated nursing assessment tools such as (pain scale, restraint, incontinence, falls risk, skin integrity, nutritional screening and depression scale), as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents and families confirmed their involvement in the assessment process. InterRAI assessments are completed by one of three trained interRAI assessors on site. (Refer criterion 1.3.3.3) |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed (refer to 1.3.4.2).  Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| 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 care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources, wound care and incontinence products were available and 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. | FA | The activities programme is provided by an activity co-ordinator who holds a Certificate in Health and Rehabilitation.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated three monthly and as part of the formal six monthly care plan review.  Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through day to day discussions and when family/whanau are visiting. Residents interviewed confirmed they find the programme enjoyable.  Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes walks outside, music, one to one, reminiscing. |
| 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 RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, and weight loss. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to a nurse wound specialist, NASC, mental health services for older persons, and a dietician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| 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 | Staff are aware of documented processes for the management of waste and infectious and hazardous substances. (Refer comments in criterion 1.3.12.1). Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.  Staff confirm they have access to appropriate personal protective equipment at all times. They were observed using gloves as required when undertaking tasks. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness (expiry date 03 April 2017) is publicly displayed. The owner stated the process to renew the warrant of fitness has commenced.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose. As observed, the testing and tagging of electrical equipment last occurred in 2014. Calibration of bio-medical equipment is current as was confirmed in documentation reviewed. There was adequate clinical equipment for the type of services offered.  Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.  External areas are safely maintained and are appropriate to the resident groups and setting.  Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment. However, not all required maintenance was documented in the maintenance book and electrical safety checks were not up to date. Staff described actions they take to clean bedpans and bowls but there is no documentation to show the required procedure.  All resident outdoor areas have seating and shaded areas. The dementia care outdoor area is secure. Residents were observed using the ramp safely on the days of audit.  The prospective owners do not intend to make any changes to the environment or services offered. However, they are aware of the audit findings and will discuss this with the current owner. They understand the need to comply with all standard, legislative and contractual requirements related to plant and equipment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes staff and visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Refer comments in criteria 1.4.2.1. |
| 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 | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms were single occupancy on the days of audit. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. This includes the secure dementia unit. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | PA Low | Larger items of laundry (sheets and towels) are sent off site to a commercial laundry and all other laundry is undertaken on site. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. As a follow up from a previous audit the service has put a policy in place and implemented actions related to the sluicing of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. An area identified in a previous complaint to the DHB was related to insufficient linen supplies. As observed on the days of audit and confirmed by staff there are adequate linen supplies.  Staff received appropriate training in the management of chemicals. Policy states that all chemicals will be stored in a lockable cupboard and labelled correctly.  There is a documented internal audit programme for cleaning which has not been kept up to date. Policy states that internal cleaning audits are to occur monthly. The last time an internal audit was completed was in October 2016. This shortfall is covered as part of criterion 1.2.3.1.  Refer comments re cleaning of equipment in criteria 1.4.2.1. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 23 January 2014. Policy states a trial evacuation is to take place six-monthly with a copy sent to the New Zealand Fire Service. The most recent documented trial evacuation occurred on 31 May 2016 and on the 28 March 2017 as requested by the auditors. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and torches were sighted and meet the requirements for residents. There is a large outdoor water storage tank. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Call system audits are completed by the facility manager on a regular basis. (There was no available documentation to show this occurs). Residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by staff. There are ‘CCTV’ cameras in common areas which are monitored on a screen located outside the facility manager’s office. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and all but six bedrooms have doors that open onto outside decked areas. Heating is provided by wall mounted electric heaters in residents’ rooms in the communal areas. There is air conditioning in the dementia unit lounge area. (Refer comments in 1.4.2.1 related to electrical safety checks and wall heater in room 8).  Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| 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 implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.  The clinical coordinator/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality/risk committee meeting. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinator/clinical nurse manager has appropriate skills, knowledge and qualifications for the role, and has been in this role for five months. She has attended an infection prevention and control study day in the last two years, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practice. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather. |
| 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 and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. 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. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager/quality, IPC committee. |
| 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 coordinators provide support and oversight for enabler and restraint management in the facility. The facility manager and clinical nurse manager are currently sharing this role owing to the previous nominated restraint coordinator no longer being employed at the facility. Both staff verbalised a sound understanding of the organisation’s policies, procedures and practice and their role and responsibilities.  On the day of audit, four hospital level care residents were using restraints and no residents were using enablers. When in use, enablers are the least restrictive and used voluntarily.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of documentation sighted in two residents’ files reviewed for restraint, and from interviews with staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval group, made up of the facility manager and the clinical nurse manager, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of residents’ files and interviews with the coordinators, that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.  Evidence of family/whānau/EPOA involvement in the decision making was on file in each case.  Use of a restraint is not always documented on the care plan. Refer to comments in criterion 1.3.4.2. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator’s involvement, and input from the resident’s family/whānau/EPOA. The restraint coordinators described the documented process. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying reason for the need to use the restraint, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed pre-restraint use assessments were sighted in the records of two residents who were using a restraint.  Ongoing six monthly assessments is not included in interRAI assessment but the facility manager stated an updated restraint assessment would be undertaken if required to reflect a change in resident status or safety. (Refer comments in 1.3.4.2). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised and the restraint coordinators described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats and low beds).  When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.  A restraint register is maintained and updated every month by the restraint coordinator/s. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to, understood that the use of restraint is to be minimised and how to maintain safety when in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | Review of residents’ files showed that the individual use of restraints is recorded in resident progress notes if there are any concerns. Restraint is discussed at the annual multidisciplinary meetings which family/whanau are invited to attend. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.  The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved. Policy is not followed related to three monthly evaluations being documented. (Refer comments in criterion 1.3.4.2). |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator/s undertake a six-monthly review of restraint use which includes all the requirements of this Standard. This information is shared at staff meetings. An annual quality review was undertaken in May 2016 and documentation sighted confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, the effectiveness of the restraint in use and any if any trends were observed. Data reviewed, minutes and interviews with the restraint coordinators confirmed that the use of restraint has been reduced by one over the past 12 months. |

# 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 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The service has a complaints/complements register in place which identifies the complaint made, the dates and actions taken. Complaints forms can be easily accessed from a holder located at the nurses’ station. Documentation shows that appropriate actions are taken when dealing with complaints, however, not all complaints are entered into the complaints register. The facility manager located documentation related to two complaints which have occurred since the last entry was made in the complaints register which identify the actions taken to date to manage the complaints. Both these complaints remain open at the time of audit. | The last recorded complaint documented in the complaints register is dated August 2016. Two recent complaints are not identified in the complaints register, one of which is related to a serious issue and remains open under police investigation. | Provide evidence that all complaints are entered into the complaints register.  180 days |
| Criterion 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs. | PA Low | One of one files reviewed evidenced an initial assessment at time of admission of a resident in the dementia unit whom affiliated with their Maori culture. The short term and long term care plan evidenced non-specific interventions and the Maori Health plan was not implemented. English was documented as the residents’ primary language however when interviewed the resident responded in Maori. Documentation evidenced regular communication with family/whanau. Family were unable to be contacted on the day of audit. | A resident whom affiliates with their Maori culture does not have a Maori Health plan | Ensure all residents who affiliate with their Maori culture are supported by a Maori Health plan.  180 days |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Moderate | The organisation has a strategic and business plan in place (February 2015). The objectives and goals documented have not been reviewed since they were put in place. Policy outlines the purpose, values, and scope of the organisation. No reporting occurs between the facility manager and the current owner. The current facility manager was unaware that regular review of the documented goals and objectives set was a requirement. | The organisation’s strategic and business plan was last reviewed in February 2015. The current owner/director stated they were unaware that they were required to monitor the set objectives and goals. | Provide evidence that the organisational planning processes are overseen by the governing body and regularly reviewed to allow monitoring of planned, coordinated and appropriate service delivery to meet the needs of residents.  60 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 Low | The overall day to day service is managed by a facility manager who has been a registered nurse since 2013. They maintain their required educational hours to meet Nursing Council requirements. They have worked at the facility since July 2016, firstly as the clinical nurse manager and then as the facility manager since November 2016. This is their first role as a facility manager. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at ongoing clinical education sessions, via two post graduate papers related to the health field. They have also commenced attendance at aged care professional development seminars.  The current owner stated during interview that all clinical matters were the responsibility of the facility manager with support from the clinical nurse manager.  The prospective owners are aware of their contractual requirements related to management (D17) under the Age Related Residential Care contract. They also have some understanding of the needs of services offered for hospital and dementia care. They confirm they would seek specialist assistance from the DHB to ensure they had full understanding and knowledge of any issues they were unclear of to enable them to meet all contractual requirements. | The facility manager is new to the role and they have no established localised networks or support from the current owner. The current owner had very limited knowledge of what is expected as the owner of an aged care facility. There are no formalised lines of communication between the facility manager and the current owner. | Provide evidence that the facility manager is supported into their role to allow them to gain confidence and experience to complete all required tasks.  180 days |
| Criterion 1.2.2.1  During a temporary absence a suitably qualified and/or experienced person performs the manager's role. | PA Moderate | Clinical staff coverage is available at the facility. The facility manager undertakes the clinical nurse manager role. The facility manager stated there is no process in place for the coverage of the facility manager’s role when they are absent for any reason. | There is no mechanism in place to ensure that during a temporary absence of the facility manager role and be undertaken. | Provide evidence that there is a process in place to allow cover for temporary absence for the facility manager by a suitable qualified and/or experienced person.  60 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 | There are documented quality and risk management systems in place. Caregivers undertake delegated audits and document findings including any deficits found but the audit schedule has not been kept up to date since November 2016. Resident satisfaction surveys are undertaken in August each year. The results of the 2016 resident satisfaction survey has yet to be collated. The food satisfaction survey results show residents are happy with the food services offered. Quality data for incidents and accidents, infection control, restraint and health and safety are collected and recorded monthly. This is confirmed during staff interviews and in staff meeting minutes sighted. | The audit schedule is not up to date. No audits were undertaken in November or December 2016 and there is no plan in place to ensure the missed audits will be undertaken in the near future. The audit schedule does not include pressure injury management. | Provide evidence that all quality and risk management systems as described in policy are implemented in a timely manner.  180 days |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Low | The service uses an off-site policy provider to ensure policies and procedures meet contractual, legislative and good practice requirements. However, only 50% of the policies, procedures or documentation sighted during the audit were up to date. Incident and accident forms were being used from an obsolete document. The facility manager stated that not all the updated policies and procedures sent to them has been reviewed or re-printed. The facility manager stated that there is no documented system in place to show when policies and procedures are due to be updated. They stated they were working their way through the policy manuals as they had time. | The service does not follow the document control management policy. Approximately 50% of the policies and procedures sighted on the days of audit were out of date and there is no system in place to show when updates are due. Obsolete forms are not always removed to prevent ongoing use. | Provide evidence that there is a system is in place to ensure the most up to date policies, procedures and documents are in use.  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 data is collected and documented monthly to cover all aspects of key components of service delivery. Information is shared at staff meetings. Analysis and evaluation of data is not always completed. With the exception of infection control data, there is np comparative data for November, December and January. Increase or decrease in restraint, falls, wounds, incidents and accidents or complaints could not be made. The facility manager has commenced a process of using graphs to show numbers, but this has just commenced (February 2017) and has not yet generated any comparative data. Food and satisfaction surveys were undertaken in August 2016. | Documentation related to evaluation and analysis of quality data is not complete. Staff meeting minutes for February did not show any numbers related to the data collected. There is no documented evaluation for the resident or food satisfaction surveys carried out in August 2016. | Provide evidence that quality improvement data is consistently analysed and evaluated and results communicated to staff, and where relevant, residents/families.  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 Low | Corrective action plans sighted for the follow up of the DHB complaints is well documented. The facility manager was aware of where to locate the corrective action plan forms but has not used them since commencing the role in November 2016. The facility manager stated that although corrective actions are not always documented they are discussed with staff. Staff confirmed they are made aware of improvements required verbally and sometimes by memos. The facility does not have a communication book but they have a folder with all memos. | Not all corrective actions are documented. For example, the challenging behaviour audit which had three recommendations for follow up have not been written up as a corrective action and no documented evidence could be found at the time of audit to show any actions had been taken to address the audit findings. A significant challenging behaviour incident which occurred in January 2017 has no corrective actions identified. | Provide evidence that corrective action data is documented to show that improvements are acknowledged and implemented by the service  180 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Staff confirmed that all incidents and accidents are documented and that they are reviewed by the facility manager prior to sign off. No documented evidence was sighted on the days of audit to show how adverse event learnings are used to identify opportunities to improve service delivery. The facility manager was able to verbalise improvements that have been put into place following incident and accidents such as the use of low beds or the introduction of walking aids post falls but this is not documented. Staff confirm they are made aware of required improvements. | There is no documentation on incident and accident forms to show what corrective actions are to be put in place to improve services. There are shortfalls identified in the adverse event which occurred and was reported to the Ministry, however no opportunities to improve service delivery as a result had been documented at the time of audit.  A significant challenging behaviour incident which occurred in January 2017 has no corrective actions identified. | Provide evidence that all data is documented to a level of detail that identifies the shortfalls, so it can be used an opportunity to improve service as required.  180 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The service has a documented orientation/induction that covers the essential components of service. Staff confirmed this during interview. Not all files had evidence of orientation completed. Of the six staff files reviewed, two did not have orientation sign off completed, two did not have any orientation documentation and two were completed. One of the incomplete orientation files reviewed belonged to the facility manager and they confirmed all orientation was completed but sign off must have been overlooked. | Three of the six files reviewed did not have evidence of completed orientation. | Provide evidence that all new staff orientation documentation is complete to identify what tasks/items have been covered.  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 Low | The service has a documented record of ongoing education for service providers for 2016 and 2017. This includes on and off site education. Staff member attendance is recorded. Not all staff appraisals are up to date and there is no documented system in place to know when they are due. Of the staff records reviewed the last recorded staff appraisal sighted was undertaken in January 2016.  Six staff files were reviewed in depth, three of the files were for staff who have been employed for less than one year. One additional file for a staff member who has been at the facility for over one year was reviewed for annual appraisal only. All three of the files reviewed for staff with over one years’ service had overdue appraisals. (One was due in January 2017, one in October 2016 and one in November 2016). Management could not provide any staff files with up to date appraisals. During interview, staff who had worked at the facility for over one year (3) were not sure if they had an annual appraisal taken within the last 12 months. | Staff appraisals are not up to date. There is no system in place to alert management when staff appraisals are due. | Provide evidence that staff appraisals are undertaken annually to meet contractual requirements.  180 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 High | Policies and procedures for medicine management were reviewed and meet requirements. All staff administering and checking of medications have completed medication competency. A medicine administration round was observed on the day of audit, however best practice was not always followed. Electronic charting evidenced a resident prescribed insulin via a ‘flexipen’ device. A registered nurse was observed to draw insulin from a prescribed insulin flexipen with another needle and syringe. The amount of insulin drawn was checked by the health care assistant as correct. The registered nurse administered the medication to the resident and acknowledged on the electronic device. A discussion with the registered nurse, clinical nurse manager and facility manager were unable to clarify why this specific practice occurred. Correct needles for the flexipen were made available, the disposal needle and syringes were removed from the medication trolley and best practice was discussed with the afternoon registered nurse on duty by the facility manager. On day two of audit the clinical nurse manager stated that having spoken to the facility manager that ‘it might be best to return to the practice of introduced syringe and needle as she was unsure of how to administer insulin from the flexipen and safe practice when changing the flexipen disposable needles’. A phone call to the pharmacist confirmed that this was not best practice.  At the time of audit, two used and unsheathed needles connected to syringes were found in the medication trolley. The registered nurse at the request of the clinical nurse manager disposed of the needles and syringes appropriately. A sharps bin was placed in the medication trolley. An incident form was completed.  The facility manger has stated that a corrective action plan will be developed to ensure that interventions are put in place to ensure best practice for safe administration of medication and safe disposal of used needles/syringes is followed. | Safe medication management and disposal of sharps processes as per policy and procedure are not being followed. | Ensure all medication is administered safely as prescribed and sharps are disposed of appropriately.  1 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | All residents admitted to the facility had written initial assessments, short term and long term care plans and evaluations provided with required timeframes. It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. However, one resident admitted in January 2017 via the hospital for respite care has not been admitted by a GP, all other GP assessments are within required timeframes. 18 of 23 residents did not have an up to date interRAI assessment. Two of 23 interRAI assessments were last completed in 2015, 11 interRAI assessments were last completed in 2016. The clinical nurse manager stated that interRAI assessments were not up to date due to high staff turn-over. No corrective action plan is in place at time of audit however a registered nurse employed recently at the facility is interRAI trained and awaiting permission and to have access to the facility database. | Not all residents had an up to date interRAI assessment or GP admission. | Ensure that all residents have an interRAI assessment and are admitted by a GP to meet contractual requirements and time frames.  180 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | All residents admitted to the facility had assessment tools completed. It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. Two of seven residents’ files were reviewed, one resident did not have documented in their short and long term care plans evidence to support the use of a moon boot supporting a fracture. One resident had evidence to show the need for a restraint, however this was not reflected in the resident’s short or long term care plan. | Not all residents had identified needs documented in the support care plan. | Ensure the needs of all residents are identified in the service delivery planning.  180 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Moderate | The documentation sighted identifies that all actions are undertaken to maintain a building warrant of fitness.  The maintenance request book shows that requests are responded too within a five working day timeframe. The person who undertakes reactive maintenance is contracted and is called in as and when required. The service does not have a long term maintenance plan in place. Maintenance was an issue raised in a complaint to the DHB. All requested maintenance was signed off as completed. However, it is noted that not all maintenance requests are placed in the book. The sanitiser on the site is non-operational. The sanitiser is not shown in the maintenance book as the current owner stated it is not for repair.  There is no sluice room but staff state they wash toilet equipment in the shower and use a chemical spray to ensure it is clean. There is no documented standard procedure to guide staff to ensure the correct procedure is undertaken.  Other items sighted and identified in the maintenance request book that require repair relate to; ripped wall paper in the rest home dining area, holes in the walls in the hospital area shower and one shower in the dementia care unit, the wall lining is exposed in one dementia area shower, the shaving plug needs replacing in one of the dementia area bathrooms, the bed in room 13 requires repair (the headboard has broken away), the wall heater in room 8 is not secure, there are exposed screw holes in the servery wall in the kitchen, and there is a loose television wire hanging down the outside ramp of the dementia care unit. The current owner and the facility manager were present when each of the above issues were found and are aware that they need to be put in the maintenance book and actioned.  Electrical safety checks have not been kept up to date and the owner/director organised for the electrician to commence the electrical safety checks on the second day of audit. The electrician stated it would take approximately one week.  Corridors are clutter free to encourage safe and independent movement of residents. Medical equipment checks occur annually (last completed in May 2016). An issue was previously raised around there being sufficient appropriate equipment and this has been addressed by the facility. | Electrical safety checks show a due date of August 2015.  There is no documented evidence of the procedure to be undertaken to ensure all toilet equipment is cleaned to comply with infection control standards.  Oxygen bottles are not secured.  Numerous items as listed above are not listed in the maintenance book for repair. | Provide evidence that all electrical equipment is regularly checked by an approved person to indicate it is safe for use. There is a documented procedure in place for staff to follow to ensure all equipment is correctly cleaned. Ensure all maintenance issues are reported, recorded and addressed. Oxygen bottles are secured.  60 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | Emergency training is part of staff orientation. Fire training is provided by an external provider. Staff can verbalise actions to take during an emergency. However, when it was requested that an overdue fire evacuation was to occur as soon as possible, the external provider stated that they had been contacted by the New Zealand Fire Service following a false alarm call-out in December 2016 to say that it appeared that staff did not understand the required stages of action to safely manage the situation. A fire evacuation drill was undertaken on the second day of audit and the external provider was happy that staff did understand the actions to be taken. Education was presented to the staff on duty. | The last recorded fire evacuation drill was dated the 31 May 2016. No documentation was sighted related to the false alarm which occurred in December 2016. (A drill was undertaken on the request of the auditor on the 28 March 2017). | Provide evidence that six monthly fire drills are maintained, documented and embedded into practice.  180 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Low | Each resident’s use of restraint is monitored and reported on by staff. Monitoring varies according to risk with no less than two hours between required checks. Restraint is used for safety reasons only, with one chair lap belt and three bedside rails in use. There are clear policies and procedures related to individual resident restraint use monitoring which state three monthly evaluations are to be undertaken. These have not been undertaken on the two files reviewed. | No evidence could be found that the facility required three monthly individual resident evaluation of restraint has occurred since July 2016. | Provide evidence that policies and procedures are followed to include three monthly evaluations of all restraint in use.  180 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.

|  |
| --- |
| No data to display |

End of the report.