# Waverley Aged Care Limited - Waverley House Rest Home

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Waverley Aged Care Limited

**Premises audited:** Waverley House Rest Home

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

**Dates of audit:** Start date: 30 June 2017 End date: 30 June 2017

**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:** 20

# 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

Waverley House rest home provides rest home level care for up to 20 residents. There was full occupancy on the day of audit.

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

The rest home has been owned and operated by two owners/directors (non-clinical) for 14 years. They are supported by a full-time registered nurse with 13 years’ experience in aged care as caregiver and registered nurse since 2014. Residents, family and the general practitioner interviewed commented positively on the care and services provided.

This audit identified areas for improvement relating to mandatory training, water storage for civil defence, care plans and aspects of medicine management.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The staff at Waverley House rest home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member’s health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

## Organisational management

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| --- | --- | --- |
| 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 low risk. |

An experienced owner/manager who has been in the role for 14 years manages the service. She is supported in her role by a registered nurse. Quality management processes are reflected in the business plans, goals, objectives and policies. There is a 2017 business plan in place. A risk management programme is in place, which includes incident and accident reporting and health and safety processes. Staff document incidents and accidents. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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

There is an admission package available prior to or on entry to the service. The registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews each resident’s needs, outcomes and goals at least six-monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurse and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three-monthly.

A diversional therapist is employed four afternoons a week and implements the flexible activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents.

Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes and special dietary requirements are met.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised. There are adequate communal shower/toilet facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Emergency systems are in place in the event of a fire or external disaster. There is a staff member on duty across 24/7 with a current first aid certificate.

## 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 service has appropriate procedures and documents for the safe assessment, monitoring and review of restraint and enablers. There were three residents with restraints and no residents with an enabler at the time of the audit. Staff receive training around restraint minimisation.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse has responsibility for implementing the infection control programme. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## 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 | 45 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 3 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with six care staff (one registered nurse (RN), four caregivers, and one diversional therapist) confirmed their familiarity with the Code. Two residents and four family members interviewed confirmed the services being provided are in line with the Code.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. An informed consent policy is implemented. All five resident files including the respite care resident contained signed consents. Resuscitation status had been signed appropriately in all files. Copies of enduring power of attorney (EPOA) were in the residents’ files as needed. The four caregivers and registered nurse (RN) interviewed, demonstrated a good understanding in relation to informed consent and informed consent processes. Family members and residents interviewed confirmed they have been made aware of and understand informed consent processes and that appropriate information had been provided.Four long-term resident files reviewed had signed admission agreements.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident’s life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. The manager and the RN operate an ‘open door’ policy. Residents and relatives confirmed they are aware of the complaints process. Caregivers interviewed were able to describe the process around reporting complaints. There have been no complaints made for 2016 and one complaint received in 2017 year-to-date. The complaint reviewed was made through the Health and Disability Commissioner (HDC) and was investigated and followed up. The HDC has sent a letter confirming that there will be no further action taken with the complaint (letter sighted).  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the manager or RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are informed about the Code.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records and resident’s privacy and dignity. House rules are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an abuse and neglect policy in place.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there were no residents who identified as Māori. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Care planning and activities goal setting include consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules. Job descriptions include: responsibilities of the position, ethics, and advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service meets the individualised needs of residents appropriate to rest home level care. The quality programme is designed to monitor: contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include: pre-employment, the requirement to attend orientation and ongoing in-service training. The manager is responsible for coordinating the internal audit programme. Monthly staff/quality meetings and regular residents’ meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by the manager and RN.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy in place. Residents are provided with a range of information on admission regarding the scope of service and any items they have to pay for that are not covered by the agreement. An interpreter is provided as required. Communication with family members is recorded on the 12 incident report forms reviewed and in the resident daily progress notes. Four family members interviewed stated they were informed and involved when needed in residents’ care. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waverley House is privately owned by the manager. The service provides care for up to 20 residents at rest home level care. On the day of the audit, there were 20 residents in total. There was one resident on respite (short term stay), one resident on a long-term support chronic health conditions contract and one resident on a mental health residential care contract. All other residents were under the age residential related contract (ARRC).There is a 2017 business plan, quality and risk plan developed, which aligns with purpose, mission and values of the business. The manager is non-clinical and has had twenty-one years aged care experience. She has been the owner/manager of Waverley House for the past 14 years. The manager is supported by an RN, who has been in the role since 2014. The RN was previously employed as a long-serving caregiver prior to commencing nursing studies. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home including attendance at provider meetings, cultural awareness and dementia care.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | The manager reported that in the event of her temporary absence the RN fills her role with support from other staff.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan is in place. The new quality system includes comprehensive policies and procedures. There is a documented process for the implementation of new policies and procedures, which includes information at staff meetings, and a signing process for staff to document when they have read policies. Staff meetings reviewed document discussion of new policies.There is a 2017 quality and risk management plan and business plan. Monitoring of the quality and risk plan is through the monthly quality/staff meetings and reports. The quality/staff meetings document: discussion and follow-up of quality data, incidents and accidents, health and safety, infection control, complaints (where they occur) and restraint. There are a series of quality improvement plans in place including new care plan templates being implemented and the new quality process and forms.The service completes internal audits as per the annual audit programme. Corrective actions have been developed for all opportunities for improvements identified through quality activities. Health and safety discussion and quality data is incorporated into the monthly quality/staff meetings. There is a specific health and safety agenda item. Staff complete hazard identification forms for identified/potential hazards. A current hazard register is in place. There was no evidence of health and safety training completed (link 1.2.7.5) |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality/staff meeting. Twelve resident related incident forms were reviewed for May 2017. The forms included a section to record family notification. All forms reviewed indicated family were informed or if family did not wish to be informed. Relatives sign a communication sheet to inform the service when and under what circumstances they would like to be informed. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The RN has a current practising certificate. Six staff files were reviewed (one RN, four caregivers and one diversional therapist). Evidence of signed employment contracts, job descriptions, orientation and training were in the files reviewed. Annual performance appraisals have been conducted for all staff as they fall due. Newly appointed staff complete an orientation that is specific to their job description. Care staff interviewed described the orientation programme that includes a period of supervision. The service has an annual training schedule for in-service education, however not all mandatory training has been completed. Staff complete competencies relevant to their roles. The RN is trained and competent in the use of the interRAI assessment tool. The RN and senior caregivers all have a first aid certificate and medication competency. This ensures that there is at least one staff member on all shifts with a first aid certificate and a current medication competency.  |
| 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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The RN is on-site from 9am to 2pm during weekdays and on-call after hours and on weekends. The RN is supported by two caregivers on the morning shift, two during the afternoon shift and one on night shift (11pm to 7am). A qualified diversional therapist is employed for 18 hours per week. A home assistant is employed seven days per week for laundry and cleaning. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner. |
| 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’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Four long-term admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN and senior caregivers who administer medications complete annual medication competencies and education is provided by the pharmacist. Medications (robotic rolls) are checked on delivery against the medication chart and any discrepancies are fed back to the pharmacy. All medications are stored safely however one resident’s controlled drugs had not been entered into the register. Standing orders are not used. There were no self-medicating residents on the day of audit. The medication fridge is monitored weekly. Ten medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. One resident did not have a medication chart or script in place for seven days. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals and home baking is prepared and cooked on-site by cooks covering the seven-day week. The cooks have completed food safety training. The four-week menu has been reviewed by the dietitian in June 2016. A council certificate is displayed for June 2017. The cook receives dietary profiles for new residents and is informed of any changes to resident’s dietary needs. Dislikes are known and accommodated. Additional or modified foods such as soft foods, pureed and diabetic desserts are provided. Residents and family members interviewed were very complimentary about the meals provided. Meals are prepared in a kitchen adjacent to the dining room and served directly to the residents. Fridge and freezer temperatures are monitored and recorded daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained.  |
| 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 | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RNs complete an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes for long-term residents under the ARCC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the care plan. The long-term care plans reflect the outcome of the assessments.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Long-term care plans reviewed for long-term residents included the need, goals and aims and interventions required to meet the required supports/needs, however not all care plans reflect the resident’s current health status. Relatives interviewed confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative involvement in the development of care plans. Short-term support needs plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. A shortfall was identified around the documentation of risks associated with restraint use, for three residents. There was evidence of allied health care professionals involved in the care of the resident.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition changes, the RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the discussion with the next of kin or representative page, sighted in the residents’ files reviewed. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for one resident with a wound. There were no pressure injuries on the day of audit. There is access to the DHB wound nurse specialist for advice for wound management as required. Continence products are available. The residents’ files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain and challenging behaviours.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a registered diversional therapist (DT) for 14 hours per week four days a week from 1.00pm – 4.30pm. The weekly programme is displayed and flexible to meet resident’s choice, for example on a fine day, residents may choose to have an outing in the van. The day the DT is not on duty there are entertainers, church groups, movies and other services such as the hairdresser. Exercises are held four mornings a week. Residents are encouraged to maintain community links such as the RSA. Birthdays and events are celebrated. Reminiscing, word builders, bowls and board games are included in the activity programme. A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six-monthly at the time of the care plan review with the RN. The service receives feedback on activities through one-on-one feedback, residents’ meetings and surveys.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six-monthly for three long-term residents. One long-term resident had not been at the service six months. One resident was on respite care. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.  |
| 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 | Referral to other health and disability services is evident in the residents’ files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents’ files. There is evidence that referrals are made for re-assessment where a resident requires an increase in level of care. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.  |
| 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 | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and product charts are readily accessible for staff in the laundry/cleaning and sluice room’s areas. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in a locked cupboard. Personal protective clothing is available for staff and was observed being worn by staff that were carrying out their duties on the day of audit.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility is a two-storey building with the top floor for staff and administration use only. The building has a current building warrant of fitness that expires 16 November 2017. There is a reactive repairs’ and maintenance plan in place and the register sighted evidenced timely response to maintenance requests. The two owners/directors are responsible for the planned maintenance programme, which includes monthly hot water temperature monitoring, calibrations and testing and tagging of equipment. There are essential contractor’s available 24-hours a day. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access and ramps to the spacious internal courtyards with seating and shade. The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury resources (if required) to safely deliver the cares as outlined in the residents’ care plans. There is a recently purchased hoist available if required.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Three bedrooms have a full ensuite. There are adequate numbers of shower rooms and toilets. Communal shower/toilet facilities have locks and shower curtains for privacy. Residents confirmed staff respect their privacy while attending to their hygiene care.  |
| 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 | All rooms are single. There is adequate room for residents to safely manoeuvre using mobility aids within the bedroom. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. Residents’ rooms are refurbished as they become vacant.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include a spacious dining area and a large main lounge. There are several smaller seating areas including a conservatory for quiet activities or visitors. Doors from the corridors open out onto a spacious courtyard/garden area. All furniture is safe and suitable for the residents. Communal areas are easily accessible to residents.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All laundry is laundered on-site in a designated laundry area with defined clean and dirty areas. There is a dedicated cleaning/laundry person Monday to Friday and caregivers’ complete basic laundry and cleaning duties at the weekends. The cleaning trolley is locked in a designated area when not in use. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Emergency management plans are in place to ensure health, civil defence and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six-monthly. The last fire evacuation drill occurred on 14 February 2017. Appropriate training, information and equipment for responding to emergencies has been part of the orientation of new staff. There is an emergency management manual in place. External providers conduct system checks on alarms, sprinklers, and extinguishers. First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. There is alternative gas heating and cooking available. Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency. There was not sufficient emergency supplies of stored water available on-site. Call bells were adequately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light up outside each room and on two display panels in the nurse’s station. Access by visitors and others is limited to the main entrance.  |
| 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 | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The RN has responsibility for coordinating and implementing the infection control programme for the service as outlined in the infection control job description. The infection control coordinator collates monthly infection rates. The infection control programme is reviewed annually, last in March 2017 and links to the quality system. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. There have been no outbreaks.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | PA Low | The infection control coordinator (RN) has been in the role two years but has not attended external infection control education. There is access to infection control expertise within the DHB, wound nurse specialist, public health and laboratory. The GP monitors the use of antibiotics.  |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation however has not been provided annually as part of the education plan (link 1.2.7.5). Staff have completed hand hygiene competencies.Resident education occurs as one-on-one education as part of providing daily cares. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly staff meetings. The service completes monthly comparisons of infection rates for types of infections. Trends are identified and analysed, and preventative measures put in place.Systems in place are appropriate to the size and complexity of the facility.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The RN is the restraint coordinator with a defined job description. On the day of the audit there were three residents with restraints (bedsides) and no residents with enablers. Restraint and challenging behaviour education is included in the training programme. Restraint use is on the agenda at the staff meetings.  |
| Standard 2.2.1: Restraint approval and processesServices 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 process is described in the restraint minimisation policy. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the GP, resident and their family/whānau. Ongoing consultation with the resident and family/whanau are evident. The files for three residents using restraints were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The risks associated with the use restraint was not linked to the care plans of three resident files reviewed (link 1.3.5.2).  |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted six-monthly and include family as evidenced in the residents’ files reviewed where restraint was in use. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5A 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 an annual training schedule for in-service education. Not all mandatory training has been completed within the required two-year period. | Mandatory training not completed during the two-year period was: Cultural awareness, Treaty of Waitangi, infection control, care planning, sexuality/intimacy, health and safety and also spirituality/counselling. | Ensure that all mandatory training is provided within the required two-year period.90 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The controlled drug register showed a history of weekly checks. Controlled drugs are stored in a secure safe. There were no residents currently receiving controlled drugs, however five fentanyl patches were sighted in the controlled safe that had not been entered into the register. One new resident did not have a medication chart or script in place on admission.  | 1) Controlled drugs that were sighted in the controlled drug safe had not been entered into the register. This was completed on the day of audit and the pharmacist was contacted to collect and return the controlled drugs to the pharmacy. The risk was therefore reduced to moderate. 2) One new resident did not have a medication chart in place for seven days. The GP had been faxed of the admission. The RN advised the GP surgery had closed due to illness, however the service did not attempt to get a pharmacy script for the dispensing of the medication.  | 1) Ensure all controlled drugs are entered into the controlled drug register and checked weekly. 2) Ensure medications are charted on admission. 7 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Two long-term care plans and one respite initial assessment and care plan documented the needs and supports to meet the resident’s current health status, as part of the ongoing assessment process.  | 1) Care plans for two residents did not document interventions to meet the residents’ current needs/supports as follows: (i) the care plan had not been updated for a resident transferred back to the facility post fractured hip, to include the surgical wound, moderate falls risk interventions and pain management and (ii) there were no documented falls prevention interventions for a resident with a high falls risk. 2) There were no documented risks associated with the use of restraint for three of three residents with restraint.  | 1) Ensure care plans reflect the needs/supports and interventions to meet the residents’ current health status. 2) Ensure risks identified for restraint use is documented in care plans. 60 days |
| Criterion 1.4.7.1Service 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 management plans are in place to ensure health, civil defence and other emergencies are covered. There is alternative gas heating and cooking available. There is sufficient food in the kitchen to last for three days in an emergency. There was not sufficient emergency water available on-site. | There was not sufficient emergency stored water available on-site for 20 residents for three litres of water per resident, over three days. There was 90 litres of stored water on-site and not the 180 litres of water required. | Ensure that there is 180 litres of water on-site for 20 residents for three litres of water over three days.90 days |
| Criterion 3.2.1The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard. | PA Low | The infection control coordinator has attended wound care education, however not any infection control specific education. The infection control coordinator completes internal infection control audits, staff orientation for infection control and hand hygiene audits.  | The infection control coordinator has not attended any formal infection control education to maintain knowledge and skills around current best practice.  | The infection control coordinator is required to maintain own knowledge in infection control practices by attending formal infection control education. 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.

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End of the report.