# Laama Holdings Limited - Epsom South 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 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:** Laama Holdings Limited

**Premises audited:** Epsom South Rest Home

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

**Dates of audit:** Start date: 18 September 2017 End date: 19 September 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:** 24

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Epsom South Rest Home provides rest home level care for up to 27 residents. The service is privately operated. It is one of two facilities operated by the same provider. One owner works at the facility as the manager, and a registered nurse (nurse manager), oversees all clinical services. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner.

At the same time as this certification audit occurring, a developmental evaluation occurred conducted by another agency to evaluate the services offered and contractual compliance for the four residents under the age of 65 years. Comments related to under 65 residents have been incorporated in to this report.

This audit has resulted in a continuous improvement rating in medication management, activities, infection control and corrective action planning and identified two areas requiring improvements relating to food service documentation and environmental maintenance.

## Consumer rights

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

Residents and 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 was 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.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was 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 residents’ needs.

A complaints register is maintained. There were no outstanding complaints at the time of audit.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. The owner/manager has worked in the role for over eight years. The nurse manager has been in the role for 18 months and is suitably qualified for the role.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements using the corrective action process. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

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 safely managed and 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

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

The facility meets the needs of residents. There is a current building warrant of fitness. Electrical equipment and clinical equipment are tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

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

The organisation has policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit. Policy contains a comprehensive assessment, approval and monitoring process related to restraint use. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

There is key lock on the front door for security reasons which is documented in policy and a signed consent was contained in all residents’ files reviewed. All residents have the key code for the front door and they have access to a second exit door which leads directly to the street. Environmental restraint is not monitored.

## Infection prevention and control

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

The infection prevention and control programme, led by an experienced and 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 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 4 | 94 | 0 | 2 | 0 | 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 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 provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. Twenty (20) of 22 residents have evidence of advance care planning. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident’s 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. The nurse manager was able to provide examples of when they would involve Advocacy Services. |
| 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 | The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Where possible, there are good links between the young residents with disabilities and their family. Families are involved, or not, as they are able or desire. Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints forms are on display at the main entrance and in the dining area so residents and visitors have easy access as required.  The complaints register reviewed showed that no complaints have been received over the past year. Policy identifies the actions to resolve complaints needs to be clearly documented to show that an agreed resolution has been reached within set timeframes. The owner/manager and the nurse manager verbalised their understanding of complaints management requirements. Minor concerns raised by residents during monthly residents’ meetings, such as sorting of laundry, are addressed using corrective action planning processes with improvements to services being made where possible.  The nurse manager is responsible for complaints management and follow up with the knowledge and support of the owner/manager. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.  There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff. The Code is displayed in residents’ bedrooms and main foyers of the facility together with information on advocacy services, how to make a complaint and feedback forms. |
| 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 attending community activities, arranging their own visits to the doctor, and participation in clubs 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. | FA | 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 whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. |
| 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 such as food preferences. 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 staff 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/palliative care team, diabetes nurse specialist, 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. |
| 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 is supported by policies and procedures that meet the requirements of the Code.  Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly quality data reports and business planning data reviews undertaken by the nurse manager and owner/manager showed adequate information to monitor performance is reported against documented planning objectives, including emerging risks and issues.  The owner/manager works at the facility Monday to Friday and is on call as required. She attends staff meetings and is aware of all issues that occur. The nurse manager stated they meet daily to exchange information about the day to day management of the facility.  The service is managed by the owner who is experienced in the role and who has owned and operated the facility for over eight years. The nurse manager is a registered nurse and has been in the role for 18 months. Both managers hold relevant qualifications related to their roles. The nurse manager’s responsibilities and accountabilities are defined in a job description and individual employment agreement. Both managers confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through ongoing education related to the aged care sector both on-site and off-site. The owner/manager attends regular seminars and meetings with the Auckland District Health Board (ADHB) and New Zealand Aged Care Association. The nurse manager has completed a post-graduate certificate in Leadership and Management and is continuing her post-graduate studies at the University of Auckland.  The service holds contracts with ADHB and the Ministry of Health (MoH). On the day of audit there were 24 residents. Two are privately paying boarders who receive meals, cleaning and assistance with medication administration. ADHB contracts consisted of 14 residents receiving services under the Age Residential Care Contract and four residents under Long Term Chronic Contracts. Four residents had MoH contracts for Younger People Under 65 years contracts.  A development evaluation process was conducted at the same time as the certification audit which involved the four residents under the age of 65 years. No areas of concern were raised by the auditor related to this audit. |
| 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 | When the owner/manager is absent, the nurse manager carries out all the required duties under delegated authority. During absences of the nurse manager, the clinical management is overseen by the nurse manager from the sister facility owned by the same operator, with assistance from the owner/manager for all non-clinical issues. Staff reported the current arrangements work well. |
| 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. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a six monthly family/resident satisfaction surveys (January and July), monitoring of outcomes, and clinical incidents including infections and falls.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, regular input into resident care planning decisions and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls and outcomes are monitored and reported against to identify if the action has resulted in a service improvement. Resident and family satisfaction surveys are completed six monthly. The most recent survey undertaken in July 2017 showed all services are meeting residents’ needs and that they are either satisfied or very satisfied with services offered. This was supported during resident and family interviews conducted during this audit. Several residents had written compliments about the care they receive.  Policies and procedures are developed by an off-site company and have been personalised to the services offered at Epsom South Retirement Home. 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 and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. New policies and updated/reviewed policies are discussed at staff meetings as shown in meeting minutes sighted.  The owner/manager and nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The owner/manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements |
| 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 | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. (Refer comments in criterion 1.2.3.8.) Adverse event data is collated, analysed and reported at all staff meetings. The owner/manager and nurse manager review all incident and accident forms daily (Monday to Friday).  The owner/manager and nurse manager described essential notification reporting requirements, including for pressure injuries. They advised that one notification of a significant event was made to the Ministry of Health, since the previous audit (08 July 2017). This related to a police investigation being put in place when a resident did not return to the facility. The resident was located on the same day and the investigation was closed.  There have been no issues based audits, coroner’s inquests or infection outbreaks since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human 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. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and an annual performance review.  Continuing education is planned on an annual basis, including mandatory training requirements. Staff confirmed during interview that they are offered appropriate education for the role they undertake, which includes on-site education with guest speakers, such as a Health and Disability Commissioner representative, and off-site ADHB training days. 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 service contracts an off-site assessor for the programme. The nurse manager is the sole registered nurse and she is competent and maintains her annual competency requirements to undertake interRAI assessments. 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 | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available from management and the GP when needed. The GP confirmed during interview that they are available on-call 24/7 and that staff do no call unnecessarily. 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 four-weeks rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff hold current first aid certificates. |
| 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 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 from the NASC and/or GP 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 facility showed appropriate documentation and communication between the two facilities and family. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly with reconciliation of medication charts two monthly.  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 and six-monthly stock 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 were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, should this be required.  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. | PA Low | The food service is provided on site by one 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.  Aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines; however, there was no documented evidence that the cleaning schedule has being implemented since April 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The temperatures and contents of three residents’ fridges were not being monitored. The cook has undertaken safe food handling training, with care staff also completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, was available.  Evidence of resident satisfaction with meals was verified by resident and family interviews, 2017 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. An example of this occurring was discussed. There is a clause in the access 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. | FA | Information is documented using validated nursing assessment tools such as a pain scale, 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. All residents have current interRAI assessments completed by the nurse manager/RN who is a trained interRAI assessor. Residents and families confirmed their involvement in the assessment process. |
| 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.  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. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is ‘excellent’. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. Interventions for the younger people with disabilities were consistent and relevant to the goals set and their 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 coordinator who has recently completed training as a diversional therapist. 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/whānau are involved in evaluating and improving the programme through discussions, residents’ meetings, and satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and interesting. The younger people with disabilities are able to participate in all the activities with other residents. Some are able to access the community independently and some access community groups for craft and socialisation. This group go shopping, to cafes, enjoy ‘pampering’, and are able to determine how they spend their leisure time. Staff assist in driving them to places and collecting them. |
| 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 and wounds. 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 mental health services for older persons. 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. The younger residents’ group have access to a wide range of health care providers and disability services, as they wish. |
| 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 follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply all chemicals and cleaning products. Management ensure that all staff are provided with relevant training such as safe chemical handling. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using this. |
| 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 29 September 2017 is publicly displayed.  Systems are in place to maintain the residents’ physical environment and facilities as fit for their purpose. The testing and tagging of electrical equipment (30 June 2017) and calibration of bio medical equipment (13 March 2017) was current as confirmed in documentation reviewed. Maintenance is managed by off-site contractors. Observation of the environment identified several areas for improvement. The environment was hazard free, residents were safe and independence is promoted.  External areas are safely maintained and are appropriate to the resident groups and setting. Ten bedrooms have direct outdoor access to covered balcony areas.  Maintenance documented in a maintenance book had been signed off as completed by the owner/director. |
| 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 two full ensuites which are shared between two bedrooms and two toilet/hand basin ensuites that are shared between two bedrooms. Appropriately secured and approved handrails are provided in the toilet/shower areas (refer comment in 1.4.2.1) and other equipment/accessories are available to promote residents’ independence. There are separated visitor and staff toilets. |
| 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. There are three bedrooms which are double rooms. Two of the bedrooms have two residents and this is consented too in the residents’ admission process. One double room only has one person in it. All other bedrooms are single accommodation. 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. There are dining and lounge areas upstairs and downstairs which provide adequate space 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. |
| 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. | FA | Cleaning and laundry is undertaken as part of the caregivers’ daily roles. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. One issue was raised during the year at the residents’ meeting (minutes confirmed) about laundry sometimes being given to the wrong resident. This had been fully addressed using the corrective action process.  The facility looks and smells clean. Staff receive safe chemical training during orientation and ongoing as part of the regular education offered. This was confirmed in interview of staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through regular visual checks by the owner manager and by the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | 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. Emergency planning is undertaken in accordance with the ADHB requirements and the nurse manager attends ADHB-community cluster services emergency management meetings.  The current fire evacuation plan was approved by the New Zealand Fire Service on the 20 June 2000. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 20 March 2017. Documentation sighted identified the fire service have been notified the next trial evacuation is to take place in September 2017. 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 gas BBQ’s were sighted and meet the requirements for the 27 residents. There is a water storage tanks on the grounds and bottled water within the facility. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Monthly call system audits are completed and 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 care staff. There is a key pad coded lock on the front door as referred to in section 2.1.1. of this report. Residents receive regular reminders in resident meetings that once the doors are secured at night they must not let visitors into the facility without staff knowledge. Staff and residents reported they feel safe. |
| 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. Residents confirmed on the days of audit that the facility is maintained at a comfortable temperature for them throughout the year. All heating is electric and residents have wall mounted heaters in their bedrooms.  Rooms have natural light, opening external windows and 10 bedrooms have doors that open onto an outdoor balcony area. The outdoor gardens and seating areas are easily accessible to all residents. |
| 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, with input from a clinical nurse specialist. The infection control programme and manual are reviewed annually.  The nurse manager/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 manager/owner and discussed at staff meetings.  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 has appropriate skills, knowledge and qualifications for the role, and has been in this role for 18 months. She has a certificate in infection prevention and control and attended relevant study days, 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 practices. |
| 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 the nurse manager/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, and 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 manager/owner and at all staff meetings. A quality improvement project was identified showing a reduction in urinary tract infections due to the introduction of twice daily fluid rounds for residents. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities. Policy covers environmental restraint related to the main door being locked via a key pad entry system. All residents were sighted using the door to exit or to let visitors in during the audit. Residents and families are informed of the keypad number upon entry to the facility and the nurse manager ensures all residents can use the key code independently. There is signed consent in all residents’ files reviewed acknowledging their awareness of the lock on the door and that they know how to use it. The door is connected to the emergency alarm system and opens automatically as required. This is not the only means of entry and exit to the building. There is another entrance via a walking pathway which is not kept lock during the day. This entry point is used by visitors and residents as observed during the audit.  On the day of audit, no individual residents were using restraints and no individual residents were using enablers. Policy states that enablers are the least restrictive form of restraint and used voluntarily at the resident’s request for safety reasons only.  The nurse manager stated that restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. The last recorded individual restraint shown in the restraint register was stopped on 11 January 2016. |
| 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 is made up of the nurse manager, owner/manager and GP. They are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents’ files and interviews with the coordinator that there are clear lines of accountability, that the environmental restraint is for safety reasons only.  Evidence of family/whānau/EPOA awareness of the environmental restraint is in all resident files. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessment for the resident’s ability to use the key pad on the front door independently is clearly documented. Policy is implemented related to initial assessment being undertaken with resident and family/EPOA input as confirmed during interviews. Completed assessment and education was sighted for environmental restraint.  All other assessment forms for individual restraint sighted in policy and procedure meet the requirements of the Standard. The nurse manager interviewed described the documented process for individual restraint use. The general practitioner is involved in the final decision on the safety of the use of the restraint should it be required for a resident. Restraint would only be implemented for safety reasons. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | At the time of audit, the service had no individual restraint or enablers in place. Staff acknowledge that all resident behaviour is managed as set out in care plans using distraction and calming techniques.  The nurse manager stated that should restraints be in use, frequent monitoring occurs to ensure the resident remains safe. Policy describes residents rights to access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.  A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and identified the current use of environmental restraint only.  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. | FA | Review of residents’ files showed that the residents ability to use the key lock on the front door is evaluated six monthly as part of each residents review process.  Families interviewed confirmed their knowledge of the front door being locked and confirmed they have been fully versed on how to enter the facility. All residents interviewed confirmed they are able to use the key lock independently. They are also aware of the alternative entry and exit from the facility which is not kept locked during the day.  The evaluation process for individual restraint documented in policy covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved. |
| 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 and owner/manager complete a quality review and audit of restraint use annually. This was last undertaken in May 2017. Restraint use is discussed at monthly staff meetings. If individual restraint were to be put in place the nurse manager confirmed that the review of restraint use would include analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out to ensure all aspects of safe environmental restraint are maintained. Staff had restraint education in May 2017 and challenging behaviour and de-escalation techniques education in September 2017. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with management and staff confirmed that the use of individual restraint ceased in January 2016. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The facility has a very low infection rate and on observation the kitchen appeared clean. The residents and families interviewed stated that they were very happy with the meals provided. The cook interviewed stated that they clean the kitchen on a daily basis and was able to show evidence of a cleaning schedule; however, there was no evidence that the schedule was being implemented.  Two residents had small fridges in their rooms and one resident’s fridge was located in the kitchen. The residents interviewed stated that they had no concerns and on observation there was no spoiled and/or expired food that the residents held in their fridges; however, there was no evidence to show monitoring of the residents’ fridge temperatures and/or regular cleaning of the fridges and checking of expired foods. | There is no documented evidence that the cleaning schedule in the kitchen is being implemented. Temperatures and contents of three residents’ fridges are not being monitored. | Provide evidence that all a cleaning schedule is maintained in the kitchen and that residents’ fridges are monitored to comply with safe food hygiene standards.  180 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | Electrical test and tagging and clinical equipment testing is up to date. This is undertaken by approved providers. New ‘sit-on’ weigh scales were purchased in August 2017. All flooring is secure and documented maintenance is completed and signed off by the owner/manager. Areas that require maintenance are one bedroom door and one bathroom handrail and screw holes in the wall. The owner/manager was aware of these issues but no documented evidence was found. The issues found do not allow all areas to be cleaned to a standard to allow infection control standards to be met. | One bedroom door (room 12) has a hole at the bottom of it and one toilet handrail is rusty and there are exposed screw holes in the wall where a piece of equipment has been removed. These issues are not documented in the maintenance requests. | Provide evidence that maintenance is undertaken to ensure all legislation is met.  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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| 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. | CI | The service is able to demonstrate that they have met this criterion and have documented, reviewed, analysed and trended data. All issues which require corrective actions are identified on a specific form. Many corrective actions have been developed into projects which have resulted in measurable service improvements. This includes infection prevention processes which have lowered urinary tract infections, medication management reconciliation processes to ensure all legislative requirements are implemented and recorded, resulting in no medication errors from this time, and the individualising of resident’s needs to ensure all needs are being met. For example, one resident voiced their dissatisfaction of the menu offered. The cook and nurse manager have developed an individual menu for the resident to reflect the approved menu requirements as set out by a registered dietitian. The resident confirmed during audit they are very happy with the food services and that their needs are met. A resident who displayed intrusive behaviour had a very detailed corrective action plan in place which included a detailed personalised activities plan to include regular community involvement. Staff education was provided to give staff a greater understanding of how to manage any escalation of the resident’s moods and staff reported the documented actions have worked very well. The measure for improvement identified less frequent use of ‘PRN’ (as required) medication and no displays of disruptive behaviour. | Epsom South Retirement Home having fully attained the criterion can in addition clearly demonstrate a review process including analysis of corrections actions to ensure safer service provision and a higher level of resident satisfaction. Documented, measurable examples of corrective actions were sighted in many areas of service and included medicine management, food services, activities and behaviour management. The actions taken included specific staff education, resident involvement and keeping family members informed. Some issues led to projects being undertaken with outcomes being clearly linked to the corrective action process. For example, the decreased incidents of intrusive behaviour is confirmed in the decreased number of incident forms sighted and by residents during interview.  All corrective actions documented identify that a review had been completed to show how services have been improved to meet residents’ needs and to improve service delivery. Staff can verbalise how quality improvements are achieved via corrective action planning and project management. |
| 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. | CI | In August of 2016, an area for improvement was identified showing that there was no established practice at the facility for reconciling medications/pharmacy charts. As a result, a discussion was had with the pharmacist and nurse manager and every two months seven medication charts are audited to ensure that the GP has reviewed medications three monthly, that the pharmacy has an identical copy of the facility medication chart for the resident, the controlled drug book is balanced correctly and all medications not needed on site at the facility are collected by the pharmacy including the collection of all original prescriptions. A recent audit in July 2017 identified that all criteria had been meet and no corrective actions were required. There have been no medication errors in the last 11 months. The next audit review is due in October 2017. | The service is rated a continuous improvement by demonstrating the introduction of a reconciliation plan to reduce and minimise the risk medication errors. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | In May of 2017 a resident was identified as presenting with intrusive challenging behaviours up to six times daily and requiring the support of pro re nata (PRN) medications two to five times daily. Due to the nature of the residents challenging behaviour this in turn effected the other residents behaviours at the facility and nursing interventions required. A discussion was had amongst staff and as a result the resident was encouraged and supported to join and attend regularly a club in the community three days a week. As a result, there have been four challenging behaviours documented for August and September 2017 with a significant reduction and need for pro re nata (PRN) medications. The resident was reviewed in August of 2017 and evidence showed (through observation and documentation), that the resident continues to not only attend the initial community group but also attends other groups. The staff interviewed stated that the resident is more settled in mood and behaviour and has become more independent with their daily activities of living and as a result other residents challenging behaviour has also reduced. The resident interviewed stated that they look forward to attending the community groups and gets up early to ‘prepare’. | The service is rated a continuous improvement by demonstrating then introduction of a specific community activity plan to reduce and minimise the risk of a resident’s challenging behaviours and the need for pro re nata (PRN) medicines. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | The cook observed in April 2017 that residents’ fluid jugs were returning to the kitchen half empty. Surveillance data also identified the facility had 10 urinary tract infections in 2016 and four urinary tract infections up until April 2017. A discussion was had amongst staff and as a result twice daily fluid rounds (that did not include normal beverages provided) was introduced. Residents had options of different flavoured beverages and extra supervision and encouragement was provided by staff. Notices were provided in the kitchen and around the facility to remind residents about the importance of fluid intake and extra training was provided and evidenced in staff meetings. Since April 2017, (five months) there have been no cases of urinary tract infections. Fluid jugs are returned empty to the kitchen. Residents interviewed stated that they look forward to the different beverages offered. Staff interviewed stated that due to a lower infection rate resident challenging behaviours related to un-wellness have also declined. The twice daily fluid rounds continue and residents continue to be monitored. | The service is rated a continuous improvement by demonstrating an increase in fluid intake for residents. As of April 2017, there have been no further identified cases of urinary tract infections. |

End of the report.