# Henderson Retirement Home Limited - Evergreen Retirement 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 HealthShare 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:** Henderson Retirement Home Limited

**Premises audited:** Evergreen Retirement Home

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

**Dates of audit:** Start date: 4 October 2017 End date: 5 October 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:** 12

# 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

Henderson Retirement Home Limited known as Henderson Retirement Home Retirement Home can provide care for up to 17 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The service is also able to care for residents requiring care under short-term contracts (respite care).

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The manager is responsible for the overall service and is supported by a registered nurse who provides clinical oversight. Service delivery is monitored.

Improvements are required to advance directives; delegation of second in charge roles; meeting minutes; security of resident records; a resident register and administration of medication.

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents’ and their families on entry to the service and when requested. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

Consent forms are provided and residents and family are given relevant information.

The manager is responsible for management of complaints and a complaints register is maintained. The complaints recorded on the register are managed according to the specified timeframes.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There is a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed by an external consultant with quality and risk reported through meetings at the service. There is a document control process in place.

There are human resource policies implemented around selection of staff, orientation and staff training and development. Staff, residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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 low risk. |

 The registered nurse is responsible for the development of care plans with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. Residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months or as when necessary according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. Residents and Family/whanau interviewed confirmed that adequate fluids and food are provided and snacks are available between meals or whenever needed.

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

A current building warrant of fitness is in place and a New Zealand Fire Service evacuation scheme is approved. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

## 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. |

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated understanding of restraint and enabler use and receive ongoing restraint education.

## 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 management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

## 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 | 39 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 5 | 1 | 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 | Residents state that they receive services that meet their cultural needs, receive information relative to their needs and that staff respect their wishes. Staff can explain rights for residents in a way that promotes choice. The posters identifying residents’ rights are displayed in the facility. Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual education programme. All staff have had training in the last year. Interviews with staff confirmed their understanding of the Code. Examples are provided on ways the Code is implemented in everyday practice, including maintaining residents' privacy; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. The auditors noted respectful attitudes towards residents on the days of the audit.  |
| 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. | PA Low | There is an informed consent policy and procedure that directs staff in relation to gathering consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. All resident files identified that informed consent is collected and recorded. Interviews with staff confirmed their understanding of the informed consent process. The service information pack includes information regarding informed consent. The registered nurse or the manager discusses informed consent processes with residents and their families during the admission process. The policy and procedure includes guidelines for consent for resuscitation/advance directives. Advanced directives for a resident deemed not competent to make a decision is signed by the doctor (who does not clearly state that a clinical decision has been made) and a family member. An improvement is required.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Written information on the role of advocacy services is provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service. Staff training on the role of advocacy services is included in training on the Code and this was last provided for staff in 2017.Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about 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 | The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirm they could visit at any time and were always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friend’s networks. Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments with staff able to take residents into the community.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The organisation’s complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place with evidence of resolution of complaints documented. A complaint occurring in 2017 was reviewed and this indicates that the complaints are investigated promptly with the issues resolved in a timely manner. The resident wrote that they were happy that the complaint had been investigated. Staff have completed training within the last year around management of complaints. The manager is responsible for managing complaints and residents and family state that these are dealt with as soon as they are identified. Residents and family members state that they have identified concerns in the past with the manager or registered nurse, they feel that they are listened to with issues resolved. All residents and family interviewed confirm that the manager has actively encouraged them to express any concerns. There have been no complaints with external authorities since the previous audit.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The manager or a registered nurse discusses the Code, including the complaints process with residents and their family on admission. The information pack includes information around rights and this can be produced in a bigger font, if required. Information is given to next of kin or an enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members can describe their rights and advocacy services particularly in relation to the complaints process.  |
| 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 | The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. The service ensures that each resident has the right to privacy and dignity. The resident’s own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility that can be used for private meetings.Caregivers report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. Practices consistent with this were observed on the days of the audit. Residents and families confirm that residents’ privacy is respected.Staff state that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training annually on abuse and neglect and can describe signs. There were no incidents of abuse nor neglect reported. Residents, staff and family interviewed confirm that there is no evidence of abuse or neglect. Staff interviewed are aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.  |
| 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 organisation has a policy that outlines the processes for working with people from other cultures. There is a Māori health policy that outlines how to work with Māori with reference to the Treaty of Waitangi. Staff report that specific cultural needs for Māori are identified in the specialised Māori assessment and in the residents’ care plans. The manager states that the service can access a kaumatua if required. This may be to support the service around tikanga protocols or general advice. The rights of the resident and family to practise their own beliefs are acknowledged in the policy.Staff who identify as Māori can provide support for any Māori residents in the service.Staff are aware of the importance of family/whanau in the delivery of care for the Māori residents. Staff have completed training within the last year around culture including the Treaty of Waitangi and appropriateness of services for Māori.  |
| 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 | The registered nurse identifies each resident’s personal needs at the time of admission through the assessment process. This is achieved with the resident, family and/or their representative as described by family interviewed. Information gathered during assessment includes the resident’s cultural values and beliefs. Staff are familiar with how translating and interpreting services can be accessed. There are a number of residents for whom English is a second language and staff and family can interpret. A number of resident records reviewed during the audit reflected a range of individual cultural needs and residents and family praised the service for being able to provide for differences. The manager, registered nurse, cook and other staff showed an ability to cater for a range of cultural needs and to make a special effort to celebrate significant days in cultural calendars.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff describe implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy. Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination or exploitation. Job descriptions include responsibilities of the position with a job description sighted in staff files sampled. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service implements policies to guide practice. These policies align with the health and disability services standards and are reviewed by an external consultant as legislation and evidence changes. There is a training programme for all staff with a high level of attendance from staff. Residents and families expressed a high level of satisfaction with the care delivered. Consultation for staff is available through the registered nurse, the general practitioner and specialists at the District Health Board including the gerontology nurse practitioner and the gerontology nurse specialist. Training is provided by specialists from the District Health Board during the year.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is provided. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family confirmed that there is a lot of communication from the manager and registered nurse and they are encouraged to visit at any time. Family contact is recorded in residents’ files. Family confirmed that they are invited to the care planning meetings for their family member and can attend the resident meetings. Family members and residents who attend the resident meetings confirmed that they are useful forums to raise issues. The attendance at resident meetings has increased since the new manager and registered nurse have been in the service. Residents sign an admission agreement on entry to the service. Those reviewed are signed on the day of admission. The admission agreement provides clear information around what is paid for by the service and by the resident.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The director visits the service at least weekly and is available to discuss any concerns as these arise. The strategic direction for the organisation is documented. The purpose, values, scope, direction, and goals of the organisation are identified and reviewed annually.There is an established organisational structure, with the manager supported by the registered nurse. Both the manager and the registered nurse started in their respective roles in August 2017. The manager has 18 months experience in aged care as a supervisor in a hospital and rest home prior to the new role. They have also had experience as a caregiver in aged care services prior to this. The registered nurse provides clinical oversight with 20 hours a week in the service. They also work in a medical centre and have 10 years’ experience as a nurse overseas and 18 months experience in aged care. Both have at least eight hours training relevant to their roles a year with training records from previous and current roles confirming this. On the day of audit, there were 12 residents in the facility including two who are under 65 years of age. There are no residents identified as being under a mental health or respite contract. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | PA Low | In the absence of manager, the director would support a senior caregiver to take on the acting role as manager. One caregiver who is also the diversional therapist has completed a level seven management certificate and is delegated as second in charge, however this acting role has not been formalised. In the past there has been a registered nurse designated as being able to relieve for the registered nurse in the event of their leave. There is no documentation that confirms that the acting registered nurse is in the role and that they have appropriate qualifications including an annual practicing certificate and experience in aged care.  |
| 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. | PA Moderate | There is a quality and risk management framework that is documented to guide practice. Quality indicators are documented and reviewed monthly. The service implements organisational policies and procedures to support service delivery. All policies are subject to review by the external consultant. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy. Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any pressure injuries; feedback from residents and family and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues. The schedule of meetings includes a monthly staff meeting which includes all aspects of the quality and risk management programme and a resident meeting monthly. Family are also able to attend the resident meetings. The meetings are well attended. Staff reported that they are kept informed of quality improvements. Meeting minutes include some personal details of individual resident needs employee performance. An improvement is required.The last satisfaction survey for family and residents showed that they are satisfied with services provided and this was confirmed by residents and family interviewed. The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise and risks are eliminated, minimised or isolated. Health and safety is audited monthly. Review of incidents, risks, accidents and clinical issues are discussed through meetings as part of the health and safety programme.  |
| 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 manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury over a certain grade; infectious disease outbreaks and changes in management. Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and can describe the importance of recording near misses. Incident reports documented had a corresponding note in the progress notes in each relevant resident record. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.  |
| 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 | The registered nurse holds a current annual practising certificates along with other health practitioners such as the general practitioner, podiatrist and pharmacist involved with the service (refer 1.2.2). Staff files include appointment documentation including signed contracts; job descriptions and reference checks. There is an appraisal process in place with staff files indicating that staff have an annual appraisal. All staff complete an orientation programme and caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Caregivers confirmed their role in supporting and buddying new staff. There is a low turnover of staff. The organisation has an annual training schedule documented with all staff attending each training offered. Some training is provided at the service by specialists from the District Health Board. The content of each session is retained along with documentation of attendance and evaluation of each session. Education and training hours are at least eight hours a year for each staff member. The registered nurse has completed interRAI training with certificates sighted.  |
| 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 staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy with sufficient staff to cover shifts if others are on leave. Staff are rostered on for a 12-hour shift across a 24-hour period with an extra staff from 7am to 1pm now in place because of the increased number of residents. The staff on the short shift support caregiving staff and complete cleaning and laundry. There are nine staff including the director who completes maintenance, care staff, a diversional therapist and manager. The registered nurse works 20 hours a week and is on call at all times. The manager is also on call but defers any clinical issues to the registered nurse. Cooks prepare all meals. Residents and families interviewed confirmed staffing is adequate to meet the residents’ needs. One to one staffing is available if requested from the mental health team for residents admitted under a mental health contract noting that there are no residents admitted under a mental health contract on the day of audit. The registered nurses and manager also state that they would call the crisis team if they require any assistance. Staff state that they can negotiate with the manager for extra staff if the acuity or numbers of residents increases.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | 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. There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.Entries are legible, dated and signed by the relevant staff member with their designation documented. Resident files are not protected from unauthorised access at all times and an improvement is required.Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public however the room containing resident records is not locked and an improvement is required. Individual residents’ files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder in the medication room. Staff stated that they read the care plans at the beginning of each shift and are informed of any changes through the handover process.  |
| 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. | PA Low | The entry to service policy includes all the required aspects on the management of enquiries and entry. Henderson retirement home information pack contains all the information about entry to the service. Assessments are documented. Screening processes are clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. An improvement is required in ensuring that there is record of all consumers entering the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| 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 | All medication entries sampled confirmed that they are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification. Medication reconciliation is conducted by the RN when a resident is transferred back to the service. The care giver was observed administering correctly. The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner and medication entries sampled on the electronic system complied with legislation, protocols and guidelines. Medications are stored in a safe and secure way in the treatment room and locked cupboard. The organisation uses the electronic system for e-prescribing, ordering, dispensing and administration which is accessed by use of individual password and generic facility log in.An annual medication competency is completed for all staff administering medications and medication training records were sighted.The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medications are stored appropriately. There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required. The medicines management system complies with current legislation, protocols and guidelines. |
| 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 | Meal services are prepared on site and served in the respective dining area. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. The resident’s weight is monitored regularly and supplements are provided to residents with identified weight loss issues. The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. |
| 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 | The RN and manager reported that all consumers who are declined entry are verbally informed but there was no record nor declines register at the service. Resident and family/whanau are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they needed. |
| 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 planned activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The diversional therapist reported that they modify activities based on the resident’s response and interests and also according to the capability and cognitive abilities of the residents. Activities include pet therapy, music, bingo, van outings, book and newspaper readings, church services respectively.The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The long-term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved. |
| 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 | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP could not be contacted to confirm that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP. |
| 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 and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location at the entrance to the facility. There have been no building modifications since the last audit.A planned maintenance schedule is implemented. Any maintenance issues identified by staff are logged and attended to by the director or contractors. Indoor and outdoor space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas for residents to sit. Equipment relevant to care needs is available and staff confirmed that there is always a sufficient amount of equipment. A test and tag programme is in place. Equipment is calibrated. There are safe external areas for residents and family to meet/use and these include paths, seating and shade.  |
| 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 | There are adequate numbers of accessible toilets/bathing facilities. Communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant or a lock system. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members report that there are sufficient toilets and showers with all bedrooms having a hand basin. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified with the ability to have privacy.  |
| 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 | There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Rooms are personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own.There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a lounge and dining area with these spaces able to be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.  |
| 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 | Laundry is completed on site with covered laundry trolleys and bags in use for transport. The laundry area has been reorganised to ensure that there are clean and dirty spaces. Dirty laundry was observed to be kept separate from clean laundry on the days of the audit. Residents and family members state that the laundry is well managed and they seldom have missing clothes. Caregivers complete laundry and cleaning duties with the extra caregiver rostered in the morning responsible for completing most. The cleaner has a locked cupboard to put chemicals in and the cleaner is aware that the trolley must be with them at all times. This was observed on the days of audit. Chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning and laundry processes are monitored through the internal audit process with no issues identified in audits.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The New Zealand Fire Service has approved an evacuation plan. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six monthly with all staff having completed training. The orientation programme includes emergency and security training. Staff confirmed their awareness of emergency procedures. There is always at least one staff member on duty with a first aid certificate.All required fire equipment is checked within required timeframes by an external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and a gas BBQ. Emergency lighting is in place. The doors are locked in the evenings. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security.The call bell system is operational with bells in each room. Those tested on the days of audit were working and staff responded to call bells in a prompt manner. Residents interviewed confirmed that staff attend promptly when a bell is activated.  |
| 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 | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. The service is designated as a smoke free service however there is an external area available for residents if they smoke. Family and residents confirmed that rooms are maintained at an appropriate temperature.  |
| 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 | Henderson Retirement Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented job description for the ICC including role and responsibilities is in place. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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. | FA | The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| 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. | PA Low |  Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. An improvement is required in ensuring that all staff are in compliance with the infection control policies and procedures. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control conducted by ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| 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 | The RN is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided. Information gathered is clearly documented in the infection log maintained by the infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented. The infection control surveillance register includes monthly infection logs and antibiotic use. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the quality meetings. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained or using enablers on the day of the audit. Environmental restraint is a gate with digital codes displayed on the entrance. Residents signed a consent and they go out and come back to the service as they please. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler. |

# 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 1.1.10.7Advance directives that are made available to service providers are acted on where valid. | PA Low | Advance directives are documented in all files reviewed. Advance directives in three resident records are signed by the resident who is deemed competent for this to be completed. Three other advance directives are signed by the doctor as not being competent to make an advance directive. Those deemed not competent have this assessed and signed for by the doctor and the family sign to state that they have had a discussion with the doctor and that they agree with the doctor’s decision. There is a lack of clarity in the documentation to state that the doctor is making a clinical decision regarding not for resuscitation and that the family is not making the decision around the advance directive on behalf of the resident.  | There is a lack of clarity around advance directive for residents deemed not competent to make a decision.The doctor signs for or not for resuscitation and the family also signs to state that they are engaged in the discussion.  |  Ensure that any advance directive is made by a resident who is competent to do so or by a doctor if a clinical decision is appropriate with this documented clearly on the advance directive form. 180 days |
| Criterion 1.2.2.1During a temporary absence a suitably qualified and/or experienced person performs the manager's role. | PA Low | There is a registered nurse who is identified as the second in charge if the registered nurse is on leave. The file for the second in charge registered nurse does not include relevant documentation such as confirmation or an annual practicing certificate, a current visa and documentation that they would be available should there be a need. The manager can identify a caregiver who is able to act as the manager when required. They have a level seven certificate in management and have been with the service for over a year. The acting role is documented however the position has not been formalised.  | Documentation to confirm a suitably qualified and/or experienced person to perform the manager or registered nurse position in the event of a temporary absence is not complete.  | Ensure that there is documentation to confirm who is suitably qualified and/or experienced to perform the manager role and who will relieve for the registered nurse during a temporary absence. 180 days |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | Quality improvement data is collected and analysed at each staff meeting with minutes indicating that there is tabling of data and discussion. The monthly meeting minutes include discussion also of clinical issues related to individual residents. The meeting minutes also include some documentation of staff and performance issues.  | Meeting minutes include details of individual resident needs and issues and some reference to employee performance with this personal information communicated to staff.  | Ensure that meeting minutes only include reference to the quality improvement programme and do not document individual resident or employee issues. 90 days |
| Criterion 1.2.9.7Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. | PA Low | There are two staff rooms that hold confidential information. One room has a cupboard used to keep the resident records in. This cupboard is not locked and the room is not able to be locked. The second staff area can be locked. Residents interviewed state that they do not access any rooms that are not their bedrooms or communal areas.  | Resident records are not held in a confidential manner.  | Keep resident records stored in a confidential manner. 90 days |
| Criterion 1.3.1.4Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Low | Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives and residents interviewed confirmed that they receive sufficient information regarding the services to be provided. There is no record of consumers entering service nor those referred back to referral agencies. | No record of consumers entering service and those referred to other services or referral agencies. | Ensure there is a record of consumers entering the service and those referred back to referral agencies.180 days |
| Criterion 3.3.1There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. | PA Low | The organisation has documented policies and procedures in place that reflect current best practice. The care giver was observed administering medication correctly though an improvement is required in using the hand gel sanitizer in between residents, not wearing gloves during medication administration and proper disposal of rubbish. | Inconsistence use of hand gel sanitizer in between residents, wearing gloves during medication administration and disposing rubbish on top of the drug trolley. | Ensure infection control practice reflect accepted good practice as per policies and procedures.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.