

St Albans Retirement Home Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	St Albans Retirement Home Limited
Premises audited:	St Albans Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 December 2014 End date: 16 December 2014
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:	56

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

Indicator	Description	Definition
	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

St Albans Retirement Village is a family owned facility that provides rest home and hospital level care for up to 67 residents. On the day of audit there were 56 residents. Occupancy included 18 hospital residents (one in a serviced apartment) and 38 rest home residents (including 27 rest home residents in the serviced apartments). The service is managed by a village manager with support from two owners, a clinical manager and registered nursing staff. There is an established quality and risk programme with support provided by an external consultant. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed seven of seven previous audit shortfalls related to identifying quality improvements following consumer survey, monitoring residents with weight loss issues, aspects of care planning, monitoring residents who self-medicate, monitoring and recording food temperatures, safe storage of chemicals in the kitchen, and conducting annual reviews of the infection control programme.

This audit identified that improvements are required in relation to completion of corrective actions following internal audits, reporting all adverse events, conducting annual appraisals for staff and aspects of the food service programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

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 low risk.
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There is an established quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Improvements are required whereby corrective actions are identified, implemented and followed through following internal audits. Key components of the quality management system link to quality and clinical meetings and staff meetings. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accident reports reviewed identified a need for the service to report the development of pressure injuries and notify relevant authorities following an outbreak. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

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.
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The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

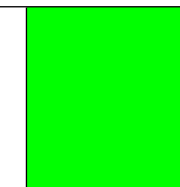
The sample of residents' records reviewed provides evidence that St Albans has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified in the long term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the six monthly reviews. Short term care plans provide comprehensive information. The service has addressed this previous finding. Resident files are integrated and include notes by the general practitioner (GP) and allied health professionals.

The activity programme is varied and promotes resident independence, involvement, emotional well-being and social interaction appropriate to the level of physical and cognitive abilities of the resident group. Spiritual and cultural preferences and needs are being met.

Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. Prescribing of medications meet legislative requirements.

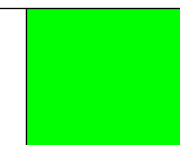
Food services and all meals are provided on site. Residents individual food preferences, dislikes and dietary requirements are assessed by the registered nurse. All staff are trained in food safety and hygiene.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service displays a current building warrant of fitness which expires on 1 June 2015.

Restraint minimisation and safe practice

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.
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Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are no residents requiring restraint or enablers.

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 control programme is reviewed annually. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	15	0	4	0	0	0
Criteria	0	37	0	5	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained with all documentation. Two concerns for 2013 from residents have been documented and managed. No written or verbal complaints have been received for 2014. The village manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy, a complaints policy, an accident/incident policy and adverse events policy. Six residents (three rest home and three hospital) and two hospital family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services</p>

		<p>and procedures. Resident/relative meetings occur three monthly and the village manager, clinical manager and registered nurses have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Family interviewed stated that they are always informed when their family member's health status changes or of any other issues arising. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Albans Retirement Village (RV) is a family owned and operated service. The owners have owned and operated St Albans RV for over 16 years. The village manager has a background in hotel and events management and has been in the role for the past 2.5 years. A registered nurse is employed as clinical manager and reports to the village manager. The facility includes an 18 bed hospital wing, 11 bed rest home wing and 38 of 53 serviced apartments which are certified to provide rest home level care. There is one hospital level resident residing in the ground floor service apartment area. The service has documented dispensation to allow this resident to reside there. The resident's room is in close proximity to the hospital dining area and nurses' station.</p> <p>On the day of audit there were 56 residents in total. There were 27 rest home residents in the service apartment wings, eleven rest home residents in the rest home (dual purpose) wing, one hospital resident in a serviced apartment wing and 17 hospital residents in the hospital wing.</p> <p>The organisation has a current strategic plan, business plan and a quality and risk management plan for 2014 with clearly defined goals. The quality programme is managed by the village manager, with support from a quality consultant and an enrolled nurse who conducts internal audits and oversees the ACE training programme. The service has an annual planner/schedule which includes audits, meetings, education and policy review time table. Aspects of the quality improvement programme required improvement (link #1.2.3.8). The quality improvement committee incorporates the village manager, clinical manager, and registered nurses. The committee meets two monthly to assess, monitor and evaluate quality care at St Albans retirement village. A mission statement sets out the vision and values of the service. The village manager and clinical manager (RN) have maintained at least eight hours annually of professional development activities related to managing a rest</p>

		home and hospital.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>St Albans Retirement Village has a current strategic business plan (2012- 2015) and quality/risk management plans. There are goals and objectives for the service in conjunction with the current implemented quality assurance and risk management programme. The village manager coordinates the quality programme with assistance from the owners and an enrolled nurse who conducts internal audits. There are 11 quality goals for 2014'</p> <p>Progress with the quality and risk management programme is monitored through two monthly quality improvement committee meetings, and three monthly staff meetings as well as an annual performance assessment tool (conducted April 2014). The quality improvement meeting agenda and the staff meeting agenda includes all relevant areas. Minutes are maintained and easily available to staff. Minutes include actions to achieve compliance where relevant.</p> <p>Discussions with the three registered nurses, one enrolled nurse and three caregivers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly with laundry, activities and food/meals as regular agenda items.</p> <p>There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. A consultant is contracted to provide policies and procedures for the service which are regularly reviewed and updated to ensure legislative compliance and best practice.</p> <p>The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Risk management plans are documented and implemented and ensure the health and safety of residents, staff, resources and environment, and business and financial risks are managed.</p> <p>Falls prevention strategies such as falls risk assessment, medication review, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. The village manager collates and analyses data to identify trends. Results are discussed with staff through the staff meetings, and</p>

		<p>quality/clinical meetings. Weekly clinical meetings are also held between the village manager, clinical manager and senior registered nurse from the rest home.</p> <p>Audits for 2014 have been completed by the enrolled nurse contracted to conduct internal audits. Corrective actions around non-compliance issues identified through internal audits have not been documented. The previous audit identified that the consumer survey which was conducted in February/March 2013 had not been evaluated and outcomes had not been communicated to residents and families. The survey (which is conducted every two years) has now been evaluated with corrective actions completed. Outcomes have been reported to residents and families via the resident meeting held in August 2013 and a newsletter published in November 2013. The service has addressed this previous finding. The survey evidences that residents are over all very satisfied with the service.</p>
<p>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.</p>	PA Low	<p>There is an accident/incident policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at two monthly quality improvement meetings and three monthly staff meetings including actions to minimise recurrence.</p> <p>The village manager advised that she is aware of the requirement to notify relevant authorities in relation to essential notifications, however, a recent infectious outbreak was not reported to the local Public Health authority.</p> <p>Incident reports for November 2014 were reviewed. The service gathers separate reports for rest home and hospital residents. One rest home resident with a pressure injury did not have a corresponding incident report completed. The sample of rest home and hospital incident forms reviewed related to 12 residents. Corresponding resident files evidence that appropriate clinical assessment and follow up has been completed by a registered nurse. Report forms were completed and family notified as appropriate. Monthly incident/accident analysis occurs with subsequent annual summary and analysis. A monthly summary of accidents and incidents is compiled by the clinical manager and village manager with subsequent analysis and investigations.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are</p>	PA Low	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses and general practitioners is</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>kept (sighted). There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed and evidence that reference checks are completed before employment is offered.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in the staff files reviewed. Competencies for all clinical staff include restraint, manual handling, hand washing, fire and evacuation, and an annual general caregiver competency review is completed. A work place support person attends the facility weekly to meet with staff if required.</p> <p>The education programme for 2014 was reviewed and has been completed as planned. Attendance records are maintained and the training programme exceeds eight hours annually. An enrolled nurse is employed for four hours a week to coordinate the education programme and responsibilities include facilitating the ACE programme (also conducts internal audits). All caregiving staff have either completed the ACE programme or are in the process of completing it.</p> <p>The clinical manager and registered nurses are able to attend external training including conferences, seminars and sessions provided by the local DHB.</p> <p>On review of five staff files, performance appraisals for two staff have not been conducted on an annual basis.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The human resource manual includes staff rostering policy, resident acuity matrix, staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home, hospital residents and service apartment residents. Advised that extra staff can be called on for increased resident requirements.</p> <p>Interviews with staff, residents and relatives identify that staffing is adequate to meet the needs of residents. The roster evidences that there are sufficient staff provided to care for the residents in all areas. Shifts include a mixture of short and long shifts and at least one registered nurse is rostered on at any one time.</p> <p>The previous audit identified that there was a hospital level resident residing in the serviced apartment area without approval from HealthCERT. There are currently 27 rest home residents and one hospital resident in the serviced apartments. The</p>

		<p>service has received a letter from the MOH allowing dispensation for accommodating one hospital resident in the serviced apartment area. This resident resides in close proximity to the rest home/hospital dining area and the hospital wing. Caregivers are on duty in the serviced apartments 24/7 and the registered nurse from the rest home provides cover during the day and evening and the hospital registered nurse provides cover during the night. The service has addressed this previous shortfall.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The registered nurses (RNs) attend two yearly syringe driver training. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. The contracted pharmacy delivers four weekly blistered medication packs and the RNs' check and record all medications on delivery - reporting any discrepancies back to the supplier.</p> <p>Medication return bins are stored securely until collected by the pharmacy. All medication trolleys are kept in locked treatment rooms. Medication fridge temperatures recorded are all within acceptable ranges.</p> <p>Medication and stock supplies are all within the expiry dates. The previous audit identified that a self-medicating rest home resident had not had checks conducted every shift to ensure the resident has taken their medications. Advised that the residents is no longer self-medicating. Advised that prior to this, the resident's medications had been checked and recorded each shift by care staff. The service has addressed this previous finding.</p> <p>Twelve medication drug charts sampled (six rest home and six hospital) met all the prescribing requirements. Each drug chart has a photo identification of the resident and allergies are recorded on the medication chart. All the regular and prn (as required) medication signing sheets are correct. The medication folder contains a medication person's specimen signature list. Approved biohazard containers are used for the disposal of sharps. Internal medication audits are conducted six monthly.</p> <p>The medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The kitchen at St Albans is centralised and provides meals to all rest home, hospital and some retirement village residents. There is a five weekly summer and winter menu. The dietitian reviewed the menu in March 2013. There are two newly employed cooks who will job share to cover seven days a week. The cooks are supported by a morning and afternoon kitchen hand. Each resident has a nutritional assessment carried out on admission which includes special instructions, feeding requirements, preferences, likes and dislikes. Fluids and hydration needs are listed. The new cook/kitchen manager advised that she has not been provided with a detailed list of resident dietary needs.</p> <p>There is at least three days of food available. All dry goods in the pantry are in labelled sealed containers and stock is rotated when food deliveries arrive. Decanted foods are not dated for expiry. Dietary needs accommodated include diabetic, pureed and gluten free. Hot food temperatures have been recorded. The service has addressed this previous finding. Advised by the kitchen staff that the fridge and freezer temperatures are checked daily however, records have not been maintained since July 2014. All perishable foods in the fridge are dated and labelled. The kitchen is well equipped with a combi-steam oven, gas stove and BBQ for alternative cooking source. There are food preparation, cooking, serving, storage, hand washing area and a separate dishwashing area. Staff wear appropriate protective apparel (hats, aprons, gloves) and safe footwear. Cleaning chemicals in the kitchen are stored securely. The service has addressed this previous finding. The new kitchen manager and cook are trained in food safety and hygiene and chemical safety. Food services staff receive feedback from the resident meetings. The food services team meets monthly. The kitchen manager has been in the role for one month and was providing induction for a second cook on the days of audit. Residents and families interviewed stated they are happy with the meals and have the opportunity to discuss food at the residents meeting or any other time with management if they have concerns.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The previous audit identified that short term care plans did not record sufficient information to guide care staff. A review of five resident files and corresponding short term care plans for wounds, infections, care following acute periods of unwellness, weight loss, and cellulitis evidence that the service records comprehensive interventions for care. The registered nurses interviewed advised that following the previous audit, they have developed pre-written short term care plans for common care needs such as infections. These evidence full and comprehensive nursing</p>

		actions for care staff to follow. The service has made improvements in this area.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Nursing care delivery is recorded at least daily in progress notes. Changes are followed up by registered nurses (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care, including electric beds, lifting and standing hoists, chair scales, shower chairs, tilting shower chair, walking frames, sensor mats, pressure relieving mattresses and cushions, hospital lounge chairs on wheels and wheelchairs. All resident related equipment has an annual functional/electrical check. There is adequate protective apparel available - gloves, aprons and masks. Infection control kits are well stocked and ready for use if needed. Dressing supplies are available and a treatment rooms are well stocked for use.</p> <p>There are seven rest home residents and three hospital residents with wounds currently being treated. Wounds include minor skins tears, skin lesions, bruising and one pressure area. The pressure area has not been reported as an adverse event via the incident reporting process (link #1.2.4.3). Each wound care plan includes an assessment, treatment plans and evaluations and progress notes sighted. Advised that wound care nurse specialist advice is readily available.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and three RN's interviewed.</p> <p>Monitoring charts for blood sugar levels, food and fluid intake charts, weight, behaviour monitoring, continence voiding chart were evidenced in use. Pain assessments or non-verbalising pain assessments are carried out on admission and reviewed at the six monthly MDT case conference or earlier for increased or new pain. Review of pain assessment forms are used. The effectiveness of prn pain relief and any "breakthrough" pain is monitored and recorded in the resident progress notes.</p> <p>Resident falls are recorded in the progress notes, reported to RN/clinical manager on accident/incident forms, family notified and GP notified. Short term care plans with interventions and on-going evaluations by the RN was evidenced. A physiotherapist</p>

		referral is initiated if required and assessment of any equipment needed. There is emergency oxygen available if required. RN's have current first aid certificates. The clinical manager, three RN's, one enrolled nurse and three caregivers interviewed described a verbal handover and written handover sheets. A handover was observed.
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>There are two activity co-ordinators to cover the rest home and hospital wings. The hospital activity co-ordinator has completed the diversional therapy (DT) units. Both staff attend DT meetings externally with a DT specialist. There are monthly local DT meetings and the activity co-ordinators meet weekly with the village manager. The rest home programme includes exercises, newspaper reading, crafts, games, walks and shopping. The hospital programme includes ball and balloon exercises, hand massage, nail care, music. The residents join together for entertainment, happy hours, art, and housie. There is a men's group, garden club, visiting school children and various demonstrations for residents. The hospital wing has a volunteer visit every morning. The company cars and van are used for outings and there is a nominated driver and activity co-ordinator to accompany residents on each outing. The wheelchair taxi is booked monthly for outings. Spiritual needs are met with interdenominational churches services monthly and catholic communions. Arrangements are made for residents to attend their churches as able. All new residents have an activity assessment on admission. An attendance list is maintained and progress notes are written at least monthly. The activity team receive feedback and suggestions for the programme from the resident and team meetings. Residents interviewed are happy with the variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans are evaluated within three weeks of admission. Long term care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted. There is a written case conference evaluation completed by the multidisciplinary team (MDT) and includes the RN, activities co-ordinator, GP, resident/family and other relevant personnel. The GP examines the residents and reviews the medications three monthly. Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long term care plan as an on-going problem. Relatives and residents interviewed confirmed they are notified of any care plan changes or changes to health status. Communication with family are written into the progress notes and identified with a</p>

		"family contacted" stamp.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	The previous certification audit identified that chemicals in the kitchen were not stored safely and securely. On a tour of the kitchen it was noted that one bottle of surface cleaner was in use and this was stored on a high framed shelf in the dish washing area. This could not be accessed by anyone other than kitchen staff. The service has addressed this previous finding.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The service displays a current building warrant of fitness which expires on 1 June 2015.
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	The previous certification audit identified that an annual review of the infection control programme had not been conducted. The quality/clinical team conducted a review of the 2013 infection prevention and control programme on 24 February 2014. The service has addressed this previous finding.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in St Albans infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the quality improvement/clinical meetings, and three monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical manager and to owners and village manager. A gastroenteritis outbreak was noted to have occurred in October 2014. This affected 13 rest home residents (no hospital or serviced apartment residents or staff). Surveillance of this outbreak was noted on the monthly summary, however, was not reported to the relevant public health authority (link #1.2.4.2).

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Documented systems are in place to ensure the use of restraint is actively minimized. The clinical manager is the restraint coordinator. The facility was not utilising restraint on the days of audit and no residents are assessed as requiring an enabler. The service has been active in reducing the use of restraint from three residents with restraint at the beginning of 2014 to no residents with restraint as of December 2014. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has appropriately documentation in place for assessment, consent, planning and monitoring of restraint should it be required. Staff education relating to restraint minimisation has been provided in 2014.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Internal audits are conducted in order to measure compliance and in keeping with the objectives of the quality programme. Internal audits conducted in 2014 included infection control, wound and skin care, restraint, environment and equipment, weight monitoring, continence, medication, laundry and cleaning. The staff member conducting the audits has identified the areas in each audit where the service is non-compliant. Corrective actions have not been developed and implemented.	Corrective action plans have not been developed and implemented following internal audits.	<p>Provide evidence that corrective actions are developed to address all identified areas of non-compliance following internal audits.</p> <p>90 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory</p>	PA Low	The village manager advised that she is aware of the requirement to notify relevant authorities in relation to	A recent gastroenteritis outbreak was not reported to the local Public Health authority.	Ensure that relevant authorities are notified appropriately

<p>and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>		<p>essential notifications. These would include those listed under Health and Disability Services (Safety) Act 2001 Section 31(5) reporting guidelines. The service had a gastroenteritis outbreak in October 2014 which affected 13 rest home residents. The infections were reported internally via the surveillance reporting method. The Public Health authority was not notified.</p>		<p>90 days</p>
<p>Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Incident and accident reports are completed for a variety of issues including staff accidents; resident falls, skin tears, bruising, behaviours; and medication errors. The sample of incident forms reviewed from November 2014 evidenced that family were notified as required and residents received appropriate clinical care and follow up. One rest home resident has a pressure area. This was not reported via the incident reporting process. Policy and procedure does not currently support this process.</p>	<p>Pressure injuries are not reported via the incident reporting process as an adverse event.</p>	<p>Ensure that pressure injuries are reported via the incident reporting process in order to identify opportunities for improvement in service delivery and outcomes for residents.</p> <p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective</p>	<p>PA Low</p>	<p>The education programme for 2014 has been implemented. Staff are able to access external education sessions relevant to their role. Staff files reviewed evidence that performance appraisals have been completed within expected</p>	<p>The clinical manager performance appraisal was conducted in September 2014. Previously this was conducted in July 2012. One registered nurse file reviewed evidenced that a performance appraisal</p>	<p>Ensure that all employees have an annual appraisal conducted as per ARC contract requirements.</p> <p>90 days</p>

services to consumers.		timeframes for one long term staff member. Two new staff files reviewed were not due for annual appraisal.	was not conducted in 2013 or 2014.	
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>There is at least three days of food and water available for emergencies. All dry goods in the pantry are in labelled sealed containers and stock is rotated when food deliveries arrive. Decanted foods in the pantry were noted not to be dated with expiry dates. Advised that any dietary need can be catered for including diabetic, pureed and gluten free. Hot food temperatures have been recorded each day for each hot dish. There is one large double door fridge and one large double door freezer. Digital temperatures are displayed on the outside of these appliances. Advised by the kitchen staff that the fridge and freezer temperatures are checked daily, however, records have not been maintained since June 2014. All perishable foods in the fridge are dated and labelled. The kitchen is well equipped with a combo-oven, gas stove and BBQ for alternative cooking source. There are food preparation, cooking, serving, storage, hand washing area and a separate dishwashing area. Staff wear appropriate protective apparel (hats, aprons, gloves) and safe footwear. Cleaning chemicals in the kitchen are stored securely.</p>	<p>a) Decanted dry foods in the pantry were not dated with expiry dates; b) fridge and freezer temperatures have not been recorded since June 2014, c) Resident nutritional and dietary requirements have not been communicated in sufficient detail to the new kitchen manager.</p>	<p>a) Ensure that all decanted foods are labelled with expiry dates; b) provide evidence that fridge and freezer temperatures have been monitored and recorded as per facility policy, c) Ensure that all kitchen staff with responsibilities for food preparation and serving are aware of each resident's nutritional and dietary (noting the cooks are currently undergoing orientation).</p> <p>90 days</p>

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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.