# Ki-Chi Service Supplies Company Limited

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Ki-Chi Service Supplies Company Limited

**Premises audited:** Raglan Trust Hospital and Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services – Sensory

**Dates of audit:** Start date: 12 February 2015 End date: 13 February 2015

**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:** 28

# 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

Raglan Trust Hospital and Rest Home provides hospital and rest home level care for up to 34 residents. On the day of audit there were 28 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The manager is a registered nurse who is appropriately qualified and experienced and is supported by a registered nurse. Feedback from residents and families was very positive about the care and services provided.

Improvements are required around maintaining a complaints register, quality systems, pain assessments, monitoring medication fridge temperatures, the updated fire evacuation plan, and restraint use.

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

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families. Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents. Evidence-based practice is evident, promoting and encouraging good practice. A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A manager and charge nurse are responsible for the day-to-day operations of the facility. Quality goals are documented for the service. Quality and risk management data is collated and trended. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Regular education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

The residents’ files are appropriate to the service type.

## 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. |

There is an admission package. A registered nurse assesses and reviews residents’ needs, outcomes and goals with the resident and/or family/whanau input. Care plans are developed and demonstrate service integration. Changes to health status and interventions are updated on the care plans to reflect the residents current health status. Residents’ files include notes by the GP and allied health professionals. Medication policies reflect legislative medicine requirements and guidelines. All staff responsible for administration of medicines complete medicine competencies. An activities programme is in place. The programme meets the recreational preferences and abilities of the residents. All food is cooked on site. All residents’ nutritional needs are identified and documented. Choices are available. Meals are well presented and a dietitian has reviewed the menu plans.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

Chemicals were stored safely throughout the facility. The building holds a current building warrant of fitness. There are single and shared rooms which are personalised. These are adequate in size with the new wing being more spacious. Communal areas are easily accessed with appropriate seating and furniture to accommodate the needs of residents. External areas are spacious, safe and well-maintained. There are adequate communal toilets and showers for the residents. Fixtures, fittings and flooring are appropriate. Cleaning and laundry services are monitored through the internal monitoring system. The temperature of the facility is comfortable and constant – the facility has solar roof panels and heat pumps. Electrical equipment is checked annually. Hot water temperatures are monitored. Emergency systems are in place.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation.

The service has two hospital-level residents using bedrails as a restraint. Residents who are using a restraint underwent a full assessment prior to restraint being put into place. This included investigating alternative strategies. Family are consulted prior to restraint use.

## 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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator and infection control nurse are responsible for providing education and training for staff. This occurs at least twice each year. The infection control manual outlines a range of policies, standards and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and educational needs.

## 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 | 44 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 7 | 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 Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Information on the Code of Health and Disability Consumers’ Rights (the Code) is displayed in a visible location at the entrance to the facility. Policy relating to the Code is implemented. Staff can describe how aspects of the Code are incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through on-going in-service education. Interviews with all five caregivers, two registered nurses, one manager, and one activities assistant reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the six resident files sampled (three rest home, three hospital). Care staff interviewed confirm consent is obtained when delivering cares. Resuscitation orders for competent residents were appropriately signed. Discussion with family members identifies that the service actively involves them in decisions that affect their relative’s lives. All six admission agreements sighted were signed within the required timeframe. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is included in the resident information pack that is provided to residents and their family on admission and on the complaints forms that are readily accessible. Pamphlets on HDC Advocacy Services are also available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Residents have access to a variety of community services, which is identified as one of the strengths of this service. A community van is available for outings. Resident/family meetings are held quarterly. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | Discussions with the residents and relatives confirmed they were provided with information on complaints and complaints forms during their entry to the service. Complaints forms are also available at the entrance to the facility. Five complaints received in 2015 (year-to-date) were reviewed with evidence of appropriate follow-up actions taken.  A record of all complaints, both verbal and written) is not being maintained by the manager using a complaints’ register. Nor are complaints being collated to identify any possible trends (link to finding 1.2.3.6). |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information pack that is provided to new residents and their family. This information is also available at the entrance to the facility. The manager/registered nurse (RN) discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the quarterly resident/family meetings. All six residents (four rest home level and two hospital level) and five relatives (one rest home level and four hospital level) interviewed reported that the residents’ rights are being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service ensures that the residents’ rights to privacy and dignity are recognised and respected at all times. The residents’ personal belongings are used to decorate their rooms. All rooms are single occupancy with the exception of one double room that is being used by two residents who have consented, along with their families, to sharing a room. Curtains are used for visual privacy.  Adequate space is available for discussions of a private nature. The caregivers interviewed 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. They report that they encourage the residents to be as active as possible. All of the residents interviewed confirmed that their privacy is being respected.  Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Any suspected instances of abuse or neglect by staff are dealt with in a prompt manner by the manager. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Policies and procedures guide staff in the care of residents who identify as Maori. The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori residents are valued and fostered within the service. They value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. During this audit there were two Maori residents living at the facility. Cultural needs are identified in their care plans.  A number of staff identify with Tikanga Maori and are role models for the other staff. Caregiver staff report that they speak Te Reo with their Maori residents. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic.  Local kaumatua and kuia support the service. Residents are encouraged to attend the local kaumatua days held at the local maraes. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The facility’s residents are from a variety of cultures. The service identifies the residents’ personal needs and desires from the time of admission, which is achieved with input from the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of physical or mental decline. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. All residents and relatives interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | House rules are discussed and signed-off by new staff during their orientation to the service. Professional boundaries are defined in job descriptions. Interviews with all five caregivers confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service is focussed on promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A general practitioner (GP) visits the facility twice per week. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits scheduled for those residents whose condition is not deemed stable.  The service receives support from Waikato District Health Board (WDHB) which includes visits from the mental health team and nurse specialists (eg: wound care, palliative care). Physiotherapy and podiatry services are provided on site on an as-needed basis. There is a robust in-service education and training programme for staff that includes competency assessments. The service has maintained strong links with the local community and encourages their active residents to remain independent.  The GP interviewed is satisfied with the level of care that is being provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.  Evidence of communication with family/whanau is documented on accident/incident forms and in the residents’ progress notes. Fifteen accident/incident forms that were reviewed across the rest home and hospital and interviews with families confirmed that family are kept informed about any change in the resident’s health status.  An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Raglan Rest Home and Hospital provides care for up to 34 residents at hospital, rest home, and residential disability levels of care. On the day of the audit there were 12 hospital level residents and 16 rest home residents. Four residents were under the age of 65. A strategic plan that includes business goals have been documented for 2015 – 2017. The manager meets weekly with the owner to discuss progress towards achieving goals.  The manager is a registered nurse with a current practising certificate who has managed this facility since 2007. The manager has maintained over eight hours annually of professional development activities related to managing an aged care service. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The manager is supported by a charge nurse/RN. After obtaining a New Zealand practising certificate 18 months ago, this individual has been working at this facility as an RN and was promoted to the role of charge nurse nine months ago. Job duties in the manager’s absence are documented. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The facility is part of the Cavell Group of aged care facilities that shares standard operating procedures and provides peer support. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control schedule is in place. Policies are regularly reviewed by all managers of the Cavell Group every one-two years unless changes occur more frequently.  Interviews with the manager and staff reflect their understanding of the quality and risk management systems that have been put into place. The monthly collating of quality and risk data includes (but is not limited to) falls, near misses, challenging behaviours, soft tissue injuries, and wandering. A resident satisfaction survey is conducted each year. Results for the 2014 survey reflect high levels of satisfaction with the services received. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Data is collated but missing in the quality and risk programme is evidence of the analysis and evaluation of the collated data; regular communication with staff relating to findings and results; and corrective action plans, where trends in data reflect opportunities for improvement.  Falls prevention strategies are in place that includes the identification of falls prevention strategies on a case-by-case basis. This includes the use of sensor mats and utilisation of physiotherapy services.  A health and safety system is in place. Regular health and safety audits take place. Hazard identification forms and a hazard register are in place. The facility has achieved secondary certification through ACC Workplace Safety Management Practice. |
| 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 | Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Fifteen incident forms were reviewed. All adverse events reflected a clinical assessment and follow-up by a registered nurse.  The manager is aware of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files that were randomly selected for review (two caregivers, one charge nurse, one staff nurse, the manager, and a cleaner) included evidence of the recruitment process, signed employment contracts, job descriptions and house rules; completed orientation programmes, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. A register of practising certificates is maintained.  An annual education schedule is being implemented that covers more than eight hours annually. The education programme for staff includes competency assessments and in-service education with invited speakers. In addition, opportunistic education is regularly provided. CareerForce education is available for the caregivers. Four caregivers have completed their CareerForce level two and dementia papers. An enrolled nurse (EN) is a CareerForce assessor. Education and training for the RNs is linked to external education provided by the Waikato District Health Board. Discussions with staff and management confirmed that a comprehensive education and training programme is in place for all staff. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The manager is a registered nurse (RN) and is supported by the charge nurse and a team of five staff RNs. A registered nurse is on site 24 hours a day, seven days a week. Two enrolled nurses with current practising certificates provide support to the caregiver staff. Staffing levels are appropriate to meet the needs of the residents, evidenced by reviewing staff rosters and discussions with the manager, staff and residents and relatives. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed at this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access. Archived records are secure in separate locked and secure areas.  Residents’ files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has a well-developed information/admission pack for potential residents and residents at entry. The information pack contains all relevant aspects of service. The manager checks that potential residents have a completed needs assessment and the service can provide the level of care. The manager stated that she has a good relationship with needs assessors, social workers, mental health team and general practitioners (GPs).  There is written information about the service in the admission pack. The admission agreement reviewed aligns with a)-k) of the ARC contract. The six admission agreements sighted had all been signed within the required time frame. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are guidelines for death, discharge, transfer documentation and follow up. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family/whanau notification of appointments and transfers. When family /whanau are not available an activities assistant accompanies them if appropriate. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Medications are managed appropriately in line with accepted guidelines. The medication cupboard was checked. Registered and enrolled nurses administer medications. All staff administering medications have completed an annual medication competency. Registered nurses also complete an annual syringe driver competency.  The service uses a Medico system for medication. All medications are checked on delivery against the medication chart and discrepancies are fed back to the supplying pharmacy. There is a small supply of hospital stock kept in a locked cupboard. All controlled drugs are kept in a locked drug safe. All controlled drugs are checked weekly.  Self-medicating residents are managed in line with accepted guidelines. There are no standing orders. There is a GP on call 24/7.  The twelve medication charts sampled included photo identification and allergies. The charts were clear and charted correctly. The signing sheets corresponded to the medication chart. There was information on some medications at the front of the medication folder e.g. insulin, warfarin. All medication charts sampled had been reviewed by the GP three monthly.  There were medications stored in the fridge but fridge temperatures were not being checked or documented. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All food is cooked in the onsite kitchen. The dining room is directly opposite. The temperature is checked before leaving the kitchen and again just before being served. There is a cook on duty daily and she is supported by a kitchen hand. All kitchen staff have completed the food and hygiene standards. There is a kitchen manual and a cleaning schedule. Chemicals are stored in a locked cupboard and safety data sheets are available. Personal protective equipment is available and worn when appropriate. There are seasonal menus on a six week cycle and these have been approved by a consultant dietitian. The cook receives dietary information for new residents and is notified of any changes including weight loss. There are nourishing drinks and supplements available for residents with weight loss. Special diets and allergies are written up, laminated and placed on the kitchen fridge. Normal and moulied meals are available. Fridge and freezer temperatures are recorded daily. Temperatures are recorded on all chilled and frozen food deliveries. All food in the fridges and freezers are dated. All food in the freezer is sealed. Stock is rotated by date. The kitchen is clean and tidy. Residents interviewed were satisfied with the food. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is an admission policy. The service would record the reason (no bed available or unable to meet service needs) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | On admission the service does the following assessments: falls risk, manual handling, pressure area, nutritional, pain, hygiene and grooming, activity requirements, food likes and dislikes and preferred name. The assessments are done by the registered nurses. Two of the six residents reviewed did not have pain assessments in spite of problems with pain and pain relief being well documented in the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed were comprehensive and demonstrated service integration and input from allied health professionals. The care plans described the requirements for the needs identified from assessments.  There is documented evidence in the care plan and in the family/whanau form of family involvement in the care plan process.  Short term care plans are in use for short term needs and changes in health. |
| 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 long term care plan and a care summary are readily available for caregivers. When a residents’ health status changes the registered nurse will review the resident and if required will ask for a review by the GP. There is documented evidence on the family/whanau form of family notification when a resident’s health status changes.  Dressing supplies are available and sighted in the well-stocked treatment room and on the dressing trolley. Continence products are available and were sighted. It is recorded in the care plan which product is needed and when. There is clear wound assessment with on-going evaluation (five skin tears and one chronic ulcer). There are no pressure areas. Monitoring forms are used when necessary as directed by the registered nurses. Forms sighted included (but not limited to) monthly weight and blood pressure, nutritional and food monitoring and behaviour monitoring. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | At present the diversional therapist (DT) is on leave. She is being covered by a senior caregiver who has completed her CareerForce caregiver training and is currently doing her DT training. She is supported by three activities assistants. Between them they work 35 hours a week. The programme runs Monday to Friday but if a special occasion arises at the weekend e.g. Easter, Mother’s Day, an activities assistant will be rostered on to come in and give out gifts and flower posies etc.  There is a weekly programme which is posted on the residents’ noticeboards. It covers a variety of activities such as newspaper reading, discussion groups, quizzes, bowls, bingo chair exercises craft programmes and outdoor walks.  There are van outings, shopping trips and once a month a visit to the club. The activities assistant who goes out on the van has a current first aid certificate. Church services are held weekly and a priest visits monthly. A singing group visits every second Thursday. Special occasions and birthdays are celebrated.  For those residents who have difficulty participating or who don’t like to come out of their rooms, the activities assistants visit and offer books and movies.  The activity plan identifies activities and community links that reflect the resident’s normal pattern of life. They are reviewed six monthly or as necessary. Residents have the opportunity to verbally feedback on the programme at residents’ meetings. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans are evaluated by the registered nurses six monthly. There is multidisciplinary input. Family/whanau have input as well if they wish. There are short term care plans available to focus on acute and short term issues. Care plans reviewed were evaluated regularly. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services was evident in the sample files. The service facilitates access to other medical and non – medical services. Examples of referrals sighted were to physiotherapy, dietitian and occupational therapist.  The manager stated that the service has access to GP’s, ambulance/emergency services, allied health and continence and wound specialists. |
| 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 | There is a waste and hazardous substance policy. All chemicals are stored in a locked cupboard. This cupboard is labelled as containing hazardous substances. Chemical training is done annually by Ecolab. Safety data sheets and product wall charts are available. Approved sharps containers are used. Personal protective equipment is available and staff were observed wearing it when appropriate. New staff are introduced to management of waste and hazardous substances at orientation. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness. All building and refurbishment is now completed. Reactive and preventative maintenance occurs. There is a maintenance /gardener person on site. There is a planned preventative maintenance plan. External contractors check and calibrate medical equipment annually and hoists are checked six monthly by the firm that supplies them. Electrical testing and tagging is done annually by an external electrician. When new residents come in, the manager checks that any electrical equipment has been tagged. Hot water temperatures are monitored and maintained. There are contractors for essential services.  The flooring is either carpet or vinyl. There is non-slip vinyl in bathroom/toilet areas. The corridors are adequate though wider in the new wing. There are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained and easily accessible (including wheelchairs). There are new large decking areas with views of the harbour. Outdoor furniture and shaded areas are available. They are currently looking at planter boxes for this area. Residents were observed enjoying this area and there were very positive comments from staff and the residents.  The registered nurses stated that they have all the equipment referred to in care plans necessary to provide care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | In the new wing there are seven ensuites. In the older wings and other rooms there are adequate numbers of communal toilets and showers. There is appropriate signage, non-slip easy clean flooring and fixtures and handrails appropriately placed. Shower rooms have privacy curtains. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms in the new wing are single and more spacious. In the older wings there are single and shared rooms. In the older wings the rooms are not as big but they are adequate to easily manoeuvre transferring and mobility equipment safely. Residents are encouraged to personalise their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are lounges in each area and the refurbishment has meant there is more space. There are large and small areas so residents can sit alone or in small groups. The dining room is directly opposite the kitchen. There is a fridge in the dining room which has cold drinks which residents may access. All lounges and the dining room are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is arranged to facilitate this. There is adequate seating and space to allow for individual and group activities to occur. The large lounge has books and puzzles available for resident use.  There is adequate space to allow freedom of movement while promoting safety for those who wander. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a cleaning policy and cleaning schedules in place. Personal protective equipment is available in the sluice rooms. Cleaners were observed to be wearing appropriate protective wear when carrying out their cleaning duties. The cleaning trolleys are locked away when not in use. Safety date sheets are in the cleaners cupboards. There is a laundry policy. All laundry is done on site. Rostered caregivers do the laundry. There is a defined clean/dirty area within the laundry. Safety data sheets are on the laundry wall. There is personal protective equipment available in the laundry. There were adequate linen supplies sighted in the linen cupboards. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Emergency and disaster policies and procedures are in place. Fire evacuation drills take place every six months. The orientation programme and mandatory education and training programme include fire and security training. Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan has not been signed off by the fire service since the recent building renovations.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. A back up three- hour battery for emergency lighting is in place.  A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one person who is available 24 hours a day, seven days a week with a current first aid/CPR certificate.  External lighting is adequate for safety and security. Security cameras are placed in strategic locations throughout the facility with a large monitor in the manager’s office. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal rooms and bedrooms are well ventilated and light. The facility has solar panels on the roof and heat pumps. The temperature of the facility is comfortable. All bedrooms have external windows which let in natural light. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The manager is the infection control coordinator and the charge nurse is the infection control nurse. The infection control nurse has completed a six month infection control course through Rotorua Polytech. Infection control meetings are held two monthly.  The facility has access to professional advice and has developed close links with the GP’s, community laboratory, the public health department and the local District Health Board (DHB).  There have been no outbreaks since the last audit. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There is an infection control committee that meets two monthly and includes staff from across the facility. The facility also has access to Bug Control, the community laboratory, GP’s, the Public Health Department and the local DHB. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and education of staff. This manual is suitable for the size and type of service. There is also the Bug Control manual for reference.  The infection control coordinator and infection control nurse are responsible for developing infection control policies. They are able to access external expertise if required.  The principles of infection control are incorporated into the kitchen, laundry and housekeeping manuals. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. The staff have annual infection control in-service from the community laboratory and the infection control nurse. The infection control nurse also does hand washing audits. The infection control coordinator and infection control nurse are booked to do an infection control seminar with Bug Control in March. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Recognised definitions of infections are in place. Individual infection control report forms are completed for all infections. These are kept in a folder. Infections are then recorded on a monthly register and a monthly report is completed by the infection control coordinator. This is displayed on the staff noticeboard and discussed at handovers. It is also reported and discussed at infection control meetings.  The facilities infection control data is benchmarked with the Cavill Group. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP’s who provide feedback/information. Identifying trends in the data is identified as an opportunity for improvement (link to finding 1.2.3.6). |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134 and includes comprehensive restraint procedures. Interviews with the caregivers and nursing staff confirm their understanding of the definitions of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There were no residents using an enabler during the audit. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A restraint approval process is in place. The restraint coordinator role is delegated to the manager, which includes a job description. All staff are required to attend restraint minimisation training a minimum of annually. Staff also complete restraint competency questionnaires. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is in place, which meets the requirements of the standard. Both residents that were using a restraint (bedrails) during the audit had restraint assessments and consent forms completed. Restraint use was linked to the residents’ care plans. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Moderate | A restraint register is in place. The register identifies two hospital-level residents as using restraints (bed rails). Restraint documentation for these two residents included restraint assessments, consultation and consent by the residents’ families, regular reviews, and links to the residents’ care plans. One (other) resident identified by the caregivers was placed in a fallout chair. The restraint coordinator reported that this occurred before the restraint assessment and consent processes were completed and has been discontinued.  The restraint assessment and on-going evaluation of restraint use includes reviewing the frequency of monitoring residents while on restraint. Staff report that they regularly check on residents while restraint is in use but this is not being documented on the restraint monitoring forms. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is reviewed weekly by staff and at a minimum of every six months by the restraint coordinator. Evidence was sighted of restraints being discontinued when deemed either unsafe or no longer necessary. The restraint coordinator/manager reported that efforts are undertaken to reduce the number of restraints that were in place with specific examples provided. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint programme, including reviewing policies and procedures and staff education is regularly reviewed. |

# 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 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Complaints are being documented with evidence of follow-up actions that are undertaken by the manager reflecting issues being acknowledged and resolved in a timely manner. These complaints have not been logged on a complaints register. | A complaints register, which includes all complaints, dates and actions, is not being maintained. | Ensure a complaints register is maintained.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data is being collected each month and collated over the period of a year. Missing is evidence of the evaluation of data to explain trends. Staff meetings are scheduled two monthly with the staff meeting agenda including discussions relating to the quality and risk management programme. Only three meetings took place in 2014. The manager reports that she frequently communicates findings with staff during impromptu meetings but these meetings are not recorded. | There is a lack of documented evidence to verify that quality improvement data is being evaluated with the results communicated regularly to staff. | Ensure quality and risk data that is collated reflects analysis and evaluation, with results communicated to staff.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Data that is being collated is graphed over the course of a year (eg, falls, near misses, challenging behaviours, soft tissue injuries, wandering). Missing is evidence of corrective action plans to address any (negative) trends. | There is a lack of documented evidence to reflect the development and implementation of corrective action plans where evidence in data suggests opportunities for improvements. | Ensure corrective actions are developed to address areas requiring improvement.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Medico packs are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Staff sign for the administration of medications on medication sheets in the medication folder. Signing sheets correspond to instructions on the medication chart and all were signed for. The medication room and cupboards were checked. Some medications are stored in the fridge but the fridge temperature was not being checked or documented. | Medication fridge temperatures are not being checked or monitored. | Ensure fridge temperatures are checked and documented weekly.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | The service does a number of assessments on admission. They are reviewed three monthly or as necessary. Pain assessments are not always being completed. | In two of the six files sampled there were no pain assessments even though residents had documented pain problems and pain relief identified in the long term care plan | Ensure that pain assessments are completed as required and reviewed regularly.  30 days |
| Criterion 1.4.7.3  Where required by legislation there is an approved evacuation plan. | PA Low | There is an approved fire evacuation scheme. However, the facility has been renovated and a new wing has been added to the facility. Exits are marked with emergency lighting in the event of a power failure. An updated fire evacuation plan has been developed and is awaiting approval by the New Zealand Fire Service. | An updated fire evacuation plan has not been approved by the New Zealand Fire Service since the addition of a new wing. | Ensure the updated fire evacuation plan is approved by the New Zealand Fire Service.  90 days |
| Criterion 2.2.3.2  Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation. | PA Moderate | A restraint assessment process is in place, which considers other alternative interventions. Restraint is only used as a last resort. Assessments are completed by the restraint coordinator/manager. Caregivers interviewed identified a resident who they decided to place in a fall out chair during the PM shift to prevent her from potentially getting out of the chair and falling. This was done before a restraint assessment had been completed. | During an interview with the caregivers, the auditor was made aware of one particular resident who was placed in a reclining chair during the PM shift to prevent her from standing and possibly falling. The restraint coordinator (manager) reported the restraint assessment process had not been completed for this resident and that she did not think that the use of restraint was safe for this resident. The use of a reclining chair for this resident has been discontinued. | Ensure that the use of an approved restraint is only used following appropriate planning, assessment and consent.  30 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Low | Monitoring forms have been developed so that staff can document evidence that the resident is monitored while using restraint. These forms are not being utilised by staff. In discussions with the caregivers, it was reported that the residents are regularly monitored every two hours at a minimum, as per the restraint assessment form. | Observations and monitoring of the resident during the use of restraint is not being documented. | Ensure the monitoring of restraint use is documented.  60 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.