

Papatoetoe Residential Care 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Papatoetoe Residential Care Limited
Premises audited:	Papatoetoe Residential Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric)
Dates of audit:	Start date: 15 April 2015 End date: 16 April 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:	24

Executive summary of the audit



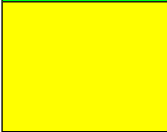
Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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

Papatoetoe Residential Care provides hospital level care for up to 30 residents. On the days of audit, there were 24 residents.

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

The management team of executive director (owner), nurse manager, clinical nurse leader and office manager are appropriately qualified and experienced for the roles they undertake. Staff education ensures staff are qualified to undertake care services. There are quality systems and processes being implemented which cover all aspects of service provision and are understood by staff. Feedback from residents and family/whānau members was very positive about the care and services provided.

There is one area for improvement related to evaluation of quality improvement processes.

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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Staff demonstrated good knowledge and practice related to respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

Maori and residents from a range of cultures reported that their individual cultural values and beliefs were respected, and this was supported in care planning documents reviewed. The service provider reports there are no known barriers to Maori residents accessing the service.

Written consent has been obtained from the residents' enduring power of attorney (EPOA) or appointed guardians. Processes are in place for advance care planning and advance directives.

The organisation provides services that reflect current accepted good practice. Evidence-based practice was observed, promoting and encouraging good practice.

Linkages with family and the community are encouraged and maintained.

The service has a documented complaints management system which was implemented. There were no outstanding complaints at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified; however, there is a lack of documented evidence to show the evaluation of corrective actions and this needs to be addressed. The quality management system included an internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff, residents and family/whānau, as appropriate. Reporting processes include the use of a balanced score card so data can easily be compared to previously collected data.

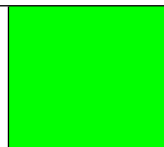
The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whānau interviews and in the 2015 satisfaction survey results.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

There was no information of a private nature on public display. The resident's records are securely maintained.

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.



Standards applicable to this service fully attained.

The entry criteria for the service's hospital level of care are clearly documented and communicated to the potential resident, family/whanau and referring agencies. If entry to the service was to be declined, a record is maintained and the potential resident and/or their family/whānau are referred to a more appropriate service.

Residents receive timely, competent, and appropriate services in order to meet their assessed need. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the resident and also contractual requirements. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

The care plans reviewed described the required support and intervention. The provision of services and interventions was consistent with, and contributed to, meeting the residents' needs. The care was evaluated at least six monthly, or sooner if there was a change in the resident's needs. Where progress was different from expected, the service responded by initiating changes to the care plan or with the use of short term care plans.

Resident support for access or referral to other health and/or disability service providers was appropriately facilitated or provided to meet the residents' needs. Staff identified, documented and minimised risks associated with each residents transition, exit, discharge or transfer.

An activities programme is managed and implemented by providing a variety of group and individual activities to meet the interests of the residents.

There are processes in place for a safe medicine management system. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The residents were highly satisfied with the meal services. The menu has been reviewed by a dietitian as suitable for the older person living in long term care.

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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There are documented emergency management response processes which were understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. The service has undertaken refurbishment of the facility but no changes were required to the evacuation plan.

The facilities meet residents' needs and provide furnishings and equipment that is regularly maintained. There is adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility heating is a mix of electricity and gas. Opening doors and windows creates a good air flow to keep the facility cool when required. The outdoor areas provide suitable furnishings and shade for residents' use. Residents and family/whānau were happy with the environment provided.

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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Policies and procedures in place reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Staff undertake annual restraint minimisation education so they have a full understanding of what is required should restraint be used. The service remains restraint free with one resident who uses enablers to ensure they remain safe whilst maintaining their independence.

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.
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There was a managed environment, which minimised the risk of infection to residents, service providers and visitors. The service has a clearly defined and documented infection control programme that is reviewed annually. There were adequate human, physical and information resources to implement the infection control programme and meet the needs of the service. The documented policies and procedures for the prevention and control of infections reflects current accepted good practice and relevant legislative requirements. These policies and procedures are suitable for the hospital level of care provided at the service.

Surveillance for infections was conducted monthly with agreed objectives, priorities, and methods that have been specified in the infection control programme. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes were acted upon, evaluated and reported to staff and management 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	45	0	1	0	0	0
Criteria	0	93	0	1	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed throughout the facility. New residents and families are provided with copies of the Code as part of the admission process.</p> <p>Staff files evidenced annual competencies completed in relation to the Code. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed respecting the residents' rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The residents' files had consent forms signed by the resident or by the enduring power of attorney (EPOA). Residents reported that they are not made to do anything they do not want to do. The caregivers interviewed demonstrated their ability to provide information that residents require in order for the residents to be actively involved in their care and decision-making. Some of the files contained copies of advance care planning and the resident's wishes for end of life care. Staff acknowledged the resident's right to make choices based on</p>

		information presented to them. All staff files evidenced an annually competency for informed consent. Staff also acknowledged the resident's right to withdraw consent and/or refuse treatment.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	The families/whanau interviewed reported that they were provided with information regarding access to advocacy services and were also encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service was listed in the resident's information booklet, with the brochure available at the entrances to the service. Education is conducted as part of the in-service education programme.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	There are no set visiting hours and family/whānau are encouraged to visit at any time. The family/whanau report there are no restrictions to visiting hours. Residents were supported and encouraged to access community services with visitors or as part of the planned activities programme.
<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>Policy and procedures identify that the organisation is committed to an effective and fair complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents, including complaints.</p> <p>Complaints management is implemented to meet policy requirements. Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education. This is confirmed during interview.</p> <p>Residents and family/whānau confirmed that the management's open door policy makes it easy to discuss concerns at any time. The complaints received since the previous audit have been managed within policy timeframes and are resolved. There are no outstanding complaints at the time of audit. This is confirmed in the complaints</p>

		<p>register sighted.</p> <p>Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. Complaints are a standing agenda item for staff meetings, as confirmed by meeting minutes sighted. They are also reported as part of the score card reporting system used by the organisation.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The family/whanāu and residents interviewed reported that the Code was explained to them on admission and was part of the admission pack. Nationwide Health and Disability Advocacy service information is part of the admission pack.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has some shared rooms, with all these rooms having privacy screening. Shared rooms can be used by married couples. The family/whanau reported that their relative is treated in a manner that shows regard to the resident's dignity, privacy and independence. The residents' files reviewed indicated that residents receive services that are responsive to their needs, values and beliefs. The family/whanau and general practitioner (GP) interviewed expressed no concerns with abuse or neglect. The family/whanau and residents interviewed reported high satisfaction with the way that the service provided care.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>Residents who identified as Maori were at the facility at the time of audit and one resident interviewed reported satisfaction with the cultural appropriateness of the care and services. The clinical nurse leader reported that there are no barriers to Maori accessing the service. Staff education has been conducted on the Maori philosophy of care, including palliative care that is commensurate with the needs of residents who identify as Maori. The caregivers interviewed demonstrated good understanding of services that meet the needs of the Maori residents and importance of whanau.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The residents' files reviewed demonstrated consultation with families on the resident's individual values and beliefs. The family/whanau reported they were consulted with the assessment and care plan development. Staff education has been conducted on the aging process and spirituality by an external provider. Staff have attended a workshop by an external education provider, which included care of lesbian and gay elders in residential care. The caregivers interviewed demonstrated good knowledge on respecting resident's culture, values and beliefs. The cultural needs of a resident who is from a different culture had their specific needs recorded.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff files reviewed had job descriptions, employment agreements and staff handbooks that had clear guidelines regarding professional boundaries. The family/whanau and residents interviewed reported they are happy with the care provided. The families expressed no concerns with breaches in professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. The DHB care guidelines for aged care are utilised. The gerontological nurse specialist visits residents as required to consult regarding residents who are referred for additional care advice.</p> <p>There is regular in-service education and staff access external education that is focused on aged care and best practice. The family/whanau and residents are satisfied with the care delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>The service promotes an environment that optimises communication through the use of interpreter services as required and staff education related to appropriate communication methods has been conducted.</p>

<p>provide an environment conducive to effective communication.</p>		<p>An example of processes in place to access appropriate communication resources for residents with special needs was observed. Policies and procedures are in place for accessing interpreter services.</p> <p>The family/whanau interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. The residents' files have a sheet that records when and for what issues family wish to be contacted. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes.</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>Strategic planning is identified in the 2014-2015 business plan. It covers all aspects of service delivery. The vision and mission statements of the organisation are documented and reviewed annually as part of the business planning process. Risk management is included in the business planning process.</p> <p>The executive director (owner) who works in the business and is at the facility at least one day per week, is an experienced manager within the aged care sector. She is supported by an office manager and two registered nurses (RNs). One RN is the nurse manager and has worked at the facility for over 29 years and the other is the clinical nurse leader (CNL) who has worked at the facility for over 12 years, five years in her current role as CNL.</p> <p>All members attend education appropriate to the role they undertake. Job descriptions identify management members' experience, education, authority, accountability and responsibility for the provision of services.</p> <p>A formalised monthly management meeting is held to review strategic planning processes to ensure they are meeting residents and community needs. Every three months all statistics collected are reviewed using data collected via the 'balanced score card' to ensure services are meeting set goals.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>The business plan outlined how the day to day operation of the service is managed and identified the reporting lines for staff to ensure the provision of services were offered to meet residents' needs.</p> <p>During a temporary absence of any member of the management team succession planning ensures all roles are fully performed to maintain service delivery. For example, the nurse manger and CNL cover for each other. Service satisfaction was reported during resident and family/whānau interviews and by the results sighted for the 2015 resident and family/whānau satisfaction surveys.</p>
<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>	<p>PA Low</p>	<p>The service has a quality and risk management system which is understood and implemented by service providers. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. All reporting is linked to management processes via a monthly score card system which is analysed by the executive director and nurse manager. This information is used to inform ongoing planning of services to ensure resident needs are met.to</p> <p>Whilst quality improvement data are collected there is very little documented evidence to show if the corrective actions put in place have been evaluated.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.</p> <p>Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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>	<p>FA</p>	<p>Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified. Actions to be taken are clearly set out in graph form for staff to follow.</p> <p>The service providers fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required.</p> <p>Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. (Evaluation of actions taken are not well documented. Refer to comments in 1.2.3.6). Family/whānau are notified of any adverse, unplanned or untoward events at times they have nominated. For example, some families only wish to be notified during daylight hours. Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles, which are repeated annually, as confirmed during staff files reviewed.</p> <p>Staff undertake training and education related to their appointed roles. Staff education includes guest speakers, off site seminars and training days and on line topics to ensure all aspects of service provision are met. This was confirmed in the education records sighted for 2014-</p>

		<p>2015.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents' needs are met by the service. No negative comments were voiced during interviews on the days of audit.</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>	FA	<p>Policy identifies staffing levels and skill mix are maintained to meet residents' needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. The service operates on a 'master roster' where each staff member is allocated set shifts. The rolling roster covers a two week period.</p> <p>The nurse manager reported that additional staff would be rostered to meet residents' needs and this was confirmed by staff interviewed. Required staffing levels and skill mix is clearly documented to meet contractual requirements.</p> <p>A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been meet in a timely manner.</p> <p>There is a registered nurse on duty at all times and all RNs hold current first aid certificates. The activities coordinator works Monday to Friday and there are dedicated kitchen and cleaning staff seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Information is entered into the resident information management system in an accurate and timely manner. Records were securely stored. Archived records were stored onsite. When required, records</p>

		<p>are appropriately destroyed.</p> <p>There is at least daily progress note entries. These records were legible and the name and designation of the staff member documented. There was also a signature register to assist with the identification of staff entries.</p> <p>All records pertaining to individual residents are integrated. Information of a private or personal nature is maintained in a secure manner and was not publicly accessible or observable at the time of audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has an enquiry form and admission and information packages for potential residents. The residents are required to have an assessment for hospital level of care. The entry criteria, assessment and entry process was clearly documented and communicated to the potential resident and family/whānau.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>When admission was required to the acute care hospital, the service utilised the DHBs transfer form/envelope. The referral process documented any risks associated with each resident's transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. In addition to the transfer form/envelope, the RN reported that the service also provided a copy of any other relevant information, such as the medication chart. A file of a resident reviewed with a recent admission to the acute care hospital evidenced that the transfer to and from the hospital was effectively managed.</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>	FA	<p>The service introduced a 'cloud based' medication recording and administration system. Most of the medicines are supplied by the pharmacy in a pre-packed administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine</p>

		<p>prescription. The GP conducts a medicine reconciliation on admission to the service and when the resident has any changes made by other specialists, with the resident's prescription updated in real time and reflected immediately in the cloud based medication management system. Safe medicine administration was observed at the time of audit.</p> <p>The medicines, controlled drugs and medicine trolley were securely stored. The medicine fridge was monitored for temperature daily; the sighted temperatures were within medicine storage guidelines. The management of the controlled drugs met legislation and best practice guidelines.</p> <p>All the medication files sampled in the electronic record had prescriptions that complied with legislation and aged care best practice guidelines. The medicine review date was recorded in the electronic records, with all residents having their medicines reviewed within the last three months.</p> <p>Medication competencies were sighted for all staff who assist with medicine management, this included the RNs and some senior caregivers. Only staff who have medicine competency can log into the medicine management system. Training for the cloud based system was conducted prior to its utilisation. Only staff who have completed the training and have a current medication competency can access the cloud based medicine management system.</p> <p>The RN reported that there were no residents who self-administer medicines. The service has policies, procedures and self-administration guidelines to assess if a resident is competent to administer their own medicines.</p>
<p>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.</p>	<p>FA</p>	<p>The menu was reviewed by a dietitian as being suitable for the older person living in long term care. No major changes have occurred to the menu since the last dietitian review. The service has a four week rotational menu with seasonal variations. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. There is culturally appropriate food provided.</p>

		<p>The residents reported being very satisfied with the meals and fluids provided. One resident commented that the food was better than a fine dining restaurant.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings, undertaken daily, meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates and ongoing in house education.</p>
<p>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.</p>	<p>FA</p>	<p>The office manager reported that they have not declined entry to any potential residents who have an appropriate needs assessment. The office and nurse manager reported that if entry to the service was to be declined, the referrer, potential resident and where appropriate their family/whānau would be informed of the reason for this and of other options or alternative services. This would be recorded on the enquiry form.</p> <p>The admission agreement contained information on the termination of the agreement. The admission agreement documented if the resident's needs changed and the service can no longer provide a safe level of care to meet the needs of the resident they would be reassessed for the appropriate level of care. The office manager reported residents requiring dementia care have been required to be transferred to a more appropriate facility. The manager also reported that some residents needs have decreased and have been referred to a rest home level of care facility.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>A mix of the electronic records and the services own assessment tools are used. The service uses additional assessment tools for skin integrity/pressure area risk, falls risk, continence assessment and nutritional assessment. The care plans sighted reflected the assessed needs of the residents. The assessment processes sighted in the resident's files reviewed covered the resident's physical, psycho-</p>

		social, cultural and spiritual needs.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The service has fully implemented the use of the interRAI assessment and use their own care plan format. All the care plans reviewed evidenced individualised care plans that reflected the resident's individual needs. The care plans reviewed demonstrated service integration. The resident's files have one main folder that contains the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations. There is a care plan synopsis that is used as a quick reference for daily routines and interventions, these are accurate, up to date and consistent with the interventions on the long term care plan.</p> <p>The residents and family/whanau interviewed reported that the staff have excellent knowledge and care skills. The families reported that the involvement that the care facility and residents have in the local community is a 'real strength' of the service. The GP interviewed expressed satisfaction with the care provided.</p>
<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>The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whanau interviewed reported satisfaction with the care and service delivery.</p>
<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>The residents are included in meaningful activities at the care facility. There are planned and spontaneous activities that covered physical, social, recreational and emotional needs of the residents. There are group and individual activities. The activities coordinator reported that they gauge the response of residents during activities and modified the programme related to feedback and the capability and cognitive abilities of the residents. The service has links with other community organisations, churches and local schools.</p>

		The activities coordinator uses the activities assessment and resident's history assessment to develop an activities programme, to ensure the programme is meaningful to the residents.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are documented, resident-focused, indicated the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. Evaluation of care is recorded on a separate form. There was also a synopsis of daily routines that summarises the interventions. Where changes are needed, the care plan was updated based on the evaluation of care. All the care plans sighted were developed, reviewed and evaluated at least six monthly.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed.</p> <p>The residents and family/whanau interviewed reported high satisfaction with the care provided at the service.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service has two main GPs, though residents were able to maintain their own GP if available. The RN or the GP arranged for any referral to specialist medical services when it was necessary. The residents' files reviewed had appropriate referrals to other health and diagnostic services. The GP interviewed reported that appropriate referrals to other health and disability services were well managed at the service.</p>
<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	<p>The organisation's waste management policy covers hazardous, controlled and non-hazardous waste management procedures. In order to protect staff, residents and visitors from harm as a result of exposure to waste products the service implements correct handling of waste procedures which are regularly audited and reviewed. Non-compliance issues are addressed via the corrective action process. There are no specific territorial requirements for the management of</p>

		<p>waste.</p> <p>Chemicals are stored securely. With the exception of one bottle of chemicals, which had a label placed on it on the day of audit, chemicals are clearly labelled and safety data sheets are available. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required.</p>
<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>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in March 2016.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurs annually and was completed in February 2015 by a registered electrician. All electrical equipment sighted had an approved testing tag. Clinical equipment is tested and calibrated by an approved provider at least annually or when required.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Regular environmental audits sighted identify that the service actively work to maintain a safe environment for staff and residents.</p> <p>The service identifies planned annual maintenance in their business plan and are undertaking a systematic upgrade of all bedrooms. They have completed seven bedrooms to date. A new dining area and entrance foyer have been completed. There are easily accessed, level surface, shaded outdoor areas for residents.</p> <p>Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>There are adequate centrally located toilet/shower facilities for residents with separate staff and visitor facilities. One toilet area was being painted on the day of audit to ensure infection control standards are met.</p> <p>Hot water temperatures are monitored and documentation identifies that they remained within safe levels.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings.</p> <p>Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and stated that privacy is never an issue.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Dining and lounge areas are separated. The areas are appropriately furnished to meet residents' needs. Some residents choose not to eat in the dining room and their choices are respected by the service. They have their meals in the lounge area or in their bedrooms.</p> <p>Residents and family/whānau voiced their satisfaction with the environment. Activities are undertaken in both the lounge and dining areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has standing operating procedures in place for cleaning. There is a dedicated storage area for cleaning equipment and chemicals. Dedicated cleaning staff maintain a daily cleaning schedule. The facility looks and smells clean.</p> <p>All laundry, including residents' personal laundry, is undertaken off site</p>

		<p>by a contracted company. During interview, residents and family/whānau confirmed they are happy with the laundry services provided. Staff interviewed confirm they always have enough laundry to meet the day to day needs.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider.</p> <p>Emergency supplies and equipment include food and water. The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. Following an upgrade to part of the building all the fire sprinkler heads have been updated. A letter sighted from the New Zealand Fire Service (April 2015) confirms that although a new fire cell had been installed the fire evacuation plan does not need to be updated as exits and points of assembly remain unchanged. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking (sighted).</p> <p>Emergency education and training for staff includes six monthly trial evacuations. No follow up actions were noted for the last two evacuations in documentation sighted.</p> <p>Appropriate security systems are in place this includes newly installed main entrance doors which have automatic locking after hours and a camera system so staff can see who is visiting after hours. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirm call bells were answered in an acceptable timeframe.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Resident areas have at least one opening window to provide natural light and ventilation. Heating is a mix of gas central heating and electric wall heaters. The facility was warm and well aired on the days of audit. Resident and family/whānau interviews confirm the facility is kept at a suitable temperature throughout the year.</p>
<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>	<p>FA</p>	<p>The clinical nurse leader (RN) has the role of infection prevention and control coordinator. The job description for the infection control coordinator role is clearly defined. There are clear lines of accountability for infection control matters in the service through the quality meetings, and relevant information is provided to the Board. The staff meeting incorporates into the infection control committee. This meeting includes input from nursing, caregiving, cleaning, kitchen administration and management. Infections are reported at handovers and if there are any concerns management is notified immediately.</p> <p>There is an outline for an infection control programme in the infection control manual. The objectives of the infection control programme are audited at least annually (last conducted in June 2014).</p> <p>The service had clear policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they did not come to work if they were unwell. There was a notice in the staff room about different infections, signs and symptoms and exclusion periods from the workplace. Notices were placed at entrances at times of the year when there was an increased risk of infections to ask visitors not to visit if they are unwell, or had been exposed to others who are unwell. The infection control coordinator reported that residents were asked to stay in their room if they have an infection risk. There was sanitising hand gel throughout the service for residents, visitors and staff.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has attended ongoing education and demonstrated current knowledge of infection prevention and control best practice. Extra advice can be sought from the GP, product supplier, DHB and hospice services as required. The infection control coordinator has dedicated time each week to meet the necessary requirements of the role. Infection control is part of the staff meeting.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>The service is transitioning to policies and procedures that have been developed by a specialist infection prevention and control advisory service. The sighted policies and procedures are referenced to current accepted good practice (updated January 2015). The infection control coordinator demonstrated sound knowledge on infection prevention and control. As observed at the time of audit staff demonstrated good infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education has been provided by the previous infection control coordinator and online modules. The current infection control coordinator is part of the nursing organisation's infection control forum and receives regular updates and links to current accepted best practice. The in-service education programme contained education and attendance sheets for infection prevention and control education session. These sessions were referenced to current accepted good practice.</p> <p>Informal education is provided for residents as required. The infection control coordinator gave examples of encouraging residents with fluids, personal hygiene and cough etiquette.</p>
<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	<p>The service conducts monthly surveillance for infections. Standardised definitions of infections, which are appropriate to the long term care setting, are used. The surveillance data is benchmarked three monthly.</p> <p>The infection and surveillance data for 2015 recorded an increase in</p>

		<p>oral infections. The analysis report showed that this increase is related to the higher number of deteriorating and palliative residents at the time. The analysis also records seasonal increase in respiratory infections. The analysis records that this was related to the change of weather and reflective of community norms. The staff meeting minutes recorded the actions implemented to reduce the infections, which included further staff and resident education, increase in fluids, hand hygiene and informal education with the resident.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policy identifies that Papatoetoe Residential Care is restraint free wherever possible. Restraint is minimised to ensure that if deemed necessary the resident is kept safe from harm to themselves and/or others and the practice occurs in a way that is culturally appropriate, respectful and safe. Policy identifies what an enabler is and what paper work and actions are required prior to an enabler being used</p> <p>At the time of audit the service has no restraint in use and one enabler. The enablers in use are to increase independence and reduce the risk of falling. This is clearly documented in the clinical file, identified on the care plan, in the restraint register and meeting minutes sighted. All documentation completed complies with policy.</p> <p>The service has comprehensive de-escalation interventions, risk behaviours and restraint approaches guidelines in place to assist staff in the safe management of residents.</p> <p>Staff are aware of the difference between an enabler and a restraint and what actions need to be taken related to the use of both.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality and improvement data are collected and analysed from across all aspects of the service. Corrective actions are identified as shown in staff meeting minutes and verified during staff and management interviews. However not all interventions put in place are clearly documented and very few corrective actions sighted have been evaluated to identify if the outcome was successful.</p>	<p>Whilst quality and improvement data are collected and analysed there is very limited documented evidence to show all the actions implemented and the actions taken have not been evaluated to identify the outcome of any given process.</p>	<p>Ensure documentation identifies all the actions taken to address issues that arise and that results are evaluated and documented to show the issue has been addressed.</p> <p>180 days</p>

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.