# Tuapeka Community Health 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:** Tuapeka Community Health Company Limited

**Premises audited:** Lawrence Rural Health Centre

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

**Dates of audit:** Start date: 15 April 2015 End date: 15 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:** 7

# 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

Lawrence Rural Health Centre can provide care for up to seven residents. On the day of the audit there were seven residents at the facility.

This certification audit was conducted against the relevant Health and Disability Standards and the service contract with the District Health Board.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner. Family and residents interviewed all spoke very positively about the care and support provided.

The manager is responsible for the overall management of the facility and is supported by the board, registered nurses and care staff.

The areas requiring improvement relate to corrective action plans; medication training; incident forms; staff files; medication competencies and the admission agreement.

## 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. |

Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Residents were treated with respect and received services in a manner that considered their dignity, privacy and independence.

Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family. Residents and family members interviewed confirmed that their rights were met during service delivery; that staff are respectful of their needs; communication was appropriate; and they had a clear understanding of their rights and the facility’s processes if these were not met.

The manager is responsible for the management of complaints and a complaints register was maintained. The residents can use the complaints forms, raise issues at the residents' meetings, or they can raise complaints directly with the manager, the registered nurse, or with any member of staff.

## 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. |

Lawrence Rural Health Centre is owned and governed by the Tuapeka Community Health Company Ltd. There is a quality and risk management system that supports the provision of clinical care and support. Policies are reviewed annually and quality and risk performance is reported through meetings at the facility and monitored by the manager through reports to the governing body. There was documented evidence of reporting on number of clinical indicators and quality and risk issues at meetings. Copies of meeting minutes are available for staff if they were unable to attend these meetings.

There is an internal audit programme and audits are completed as per the programme.

There are human resource policies documented around recruitment, selection, orientation and staff training and development. Validation of current annual practising certificates for registered nurses and other health professionals has occurred. Staff files reviewed provided evidence that improvement is required to ensure all staff files have documentation of orientation, job descriptions and employment agreements.

In-service education has been provided for staff, however not all staff that administer medicines have completed medication training and this requires an improvement.

Staff identified that staffing levels were adequate and interviews with residents and relatives demonstrated that they had adequate access to staff to support residents when needed.

Resident information was entered into a register in an accurate and timely manner.

## 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 medium or high risk and/or unattained and of low risk. |

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans were consistent with meeting residents' needs.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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. |

Lawrence Rural Health Centre has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician.

Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner’s room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade 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. |

Restraint minimisation and safe practice policy records that if enablers were to be used; these will be voluntary and the least restrictive option to maintain independence, safety and comfort. Staff demonstrated knowledge of restraint and enabler use and confirmed none were in use at audit. There was no evidence of restraint or enabler use on audit day.

## 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. |

Infection control management systems are in place to minimise the risk of infection to residents, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all staff as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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 | 40 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 88 | 0 | 4 | 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 | Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the in-service education programme. Interviews with staff confirmed their understanding of the Code. Staff were observed to maintain residents' privacy, giving residents’ choices and encouraging their independence. The auditors noted respectful attitudes towards residents on the day of the audit.  The information pack provided to residents on entry to the service includes how to make a complaint, code of rights pamphlet and advocacy information. |
| 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 | There is an informed consent policy and procedure that directs staff in relation to obtaining informed consent. Staff, residents and family interviewed confirmed that residents and family were aware of care plan interventions. All resident files identified that informed consent was documented. Interviews with staff confirmed their understanding of the informed consent processes. The registered nurses discuss informed consent processes with residents and their families/whānau during the admission process.  The policy and procedure included guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives. |
| 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 provided to residents and families on admission. Resident information around advocacy services is available at the facility.  Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services. The residents’ files included information on residents’ family/whanau and chosen social networks. |
| 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 | Residents’ family members are invited to the residents’ meetings, confirmed at interviews with the manager, staff, residents and family. A newsletter is produced by the facility and sent to family members. The manager stated there is an up to date family data base for families outside of the district to inform them of the service happenings via email.  The service has an open visiting policy, which was evident at the audit. Residents may have visitors of their choice at any time. Families interviewed confirmed they could visit at any time and are always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friends networks. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaint policy and procedure is in line with the Code. The complaint forms are provided to the resident and their family on admission and were available at the facility.  A complaints register is in place and up to date. There were two complaints in 2013 and one complaint in 2014 and these were reviewed. All complaints reviewed indicated that the complaints were investigated promptly with the issues resolved to the satisfaction of the complainant.  Residents and family members interviewed stated that they would feel comfortable complaining and were able to describe their rights and advocacy services in relation to the complaints process. The manager stated that there had been no complaints with the Health and Disability Commission since the previous audit or with other authorities. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | In interviews the manager and the registered nurses confirmed the Code, including the complaints process was discussed with residents and their family on admission.  Residents and family interviewed confirmed their rights were being upheld by the service. Information regarding the Health and Disability Advocacy Service was displayed at the facility. Information on the advocacy service was also provided in the admission pack. |
| 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 has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and the on-going residents’ assessments included gaining details of the residents’ beliefs and values. Resident files reviewed identified that cultural and /or spiritual values and individual preferences are addressed. The manager interviewed confirmed church services are held at the facility.  Discussions of a private nature are held in the resident’s room and there are areas in the facility which are used for private meetings and discussions.  Residents and families interviewed and auditor observation confirmed the residents’ privacy was respected.  The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training on abuse and neglect at orientation and at the in-service education programme. |
| 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 | The service has a documented Maori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan. There were no Maori residents residing at the facility during the audit. There are two staff members who identified as Maori. |
| 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 services records each resident’s personal needs from the time of admission, in consultation with the resident and where appropriate their family. Information gathered during the initial and the ongoing assessments includes the resident’s cultural values and beliefs. This information is used to develop resident’s care plan.  Residents and family interviewed confirmed they had choices with the resident determining when cares occurred and choices in activities. Care staff were able to give examples of how choice was given to residents. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | In interviews, staff were aware of good practice and professional boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Policies and procedures: job descriptions; employment agreements and code of conduct record professional boundaries and are available to staff. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Policies and procedures align with the Health and Disability Services Standards and were reviewed annually. A physiotherapist is available for residents’ assessments and treatment, if this is required and for annual staff training in manual handling, stated by the manager.  Residents and families interviewed expressed a high level of satisfaction with the care delivered.  The key projects implemented since last audit at the facility included: the response to resident feedback around outings leading to obtaining of a larger van with wheelchair hoist and building of a glasshouse for residents’ use. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any untoward event. Family were informed if the resident had an incident, accident, and change in health or a change in need, as evidenced in completed accident/incident forms and in residents’ files. Interviews with family members confirmed they were kept informed of the care requirements and health status of their family member and are able to attend resident meetings.  There were no residents requiring interpreting services. The information pack was available in large print and this could be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lawrence Rural Health Centre is owned and governed by the Tuapeka Community Health Company Ltd. The health centre includes a medical centre as well as the medical/aged care facility. The service has a current business plan and quality plan and the scope, direction and goals of the organisation are identified.  The manager is responsible for the overall management of the facility and reports to the board of directors. The manager has been in the role for over two years with previous experience as a director of the organisation. The manager has completed at least eight hours training relevant to their role per year.  The service provides care for total of seven beds: five rest home beds and two medical beds used for respite and short stay. The manager advised the two medical beds were not used for long term residents assessed as requiring hospital level of care. On the day of audit there were seven rest home residents, five permanent and two respite residents. |
| 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 the board, receptionist, registered nurses and long-standing and experienced care staff. The manager stated during their absence in the past the receptionist had conducted the role. |
| 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 service has a quality and risk management system that includes a business plan and a quality plan. There was evidence of the manager’s reports to the trust. Interview with one of the directors confirmed the manager attends board meetings and reports provide up to date information.  The service has policies and procedures to support service delivery to residents. The manager stated all policies were reviewed annually and as required, with all policies current. New and revised policies are presented to staff to read and staff sign to say that they have read and understood.  Service delivery is monitored through complaints, review of incidents and accidents (refer to 1.2.4.3) and implementation of an internal audit programme. Corrective action plans are not always documented and implemented when shortfalls are identified.  Meeting minutes evidenced communication with staff around aspects of quality improvement and risk management. The resident meeting minutes evidenced residents and family were informed of any changes. Staff reported that they were kept informed of quality improvements.  There was an annual family and resident satisfaction survey with a high level of satisfaction documented.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Hazards are addressed or risks minimised or isolated. |
| 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. | PA Low | In interview, the manager was aware of situations in which the service would need to report and notify statutory authorities. There have been no events since the last audit when authorities have had to be notified.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff understood the adverse event reporting process and their obligation to documenting all untoward events. The manager’s report to the trust was reviewed and evidenced an annual report on accidents/incidents for 2014.  The incident reports reviewed had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event. However, accident/ incident forms were not consistently fully completed or signed off in timely manner and not integrated into residents’ files. |
| 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. | PA Low | There are human resource policies including recruitment, selection, orientation and staff training and development. Not all required documentation is available in staff files sampled. The registered nurses have current annual practising certificates along with other health practitioner’s involved with the service.  The service has in place an orientation programme that provides new staff with relevant information for safe work practice.  Discussions with the manager and clinical staff confirmed that an in-service training programme is in place that covers relevant aspects of care and support (refer to 1.3.12.3). The programme exceeds eight hours annually. Staff have access to on- line training as an additional learning opportunity. Staff had up to date performance appraisals, confirmed at interviews and sighted in files. First aid certificates are held in the staff files. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy is the foundation for work force planning. Staffing levels were reviewed and identified numbers and appropriate staff skill mix for service delivery to residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. There is one registered nurse on each morning with on call provided by the registered nurses and the manager.  Residents and families interviewed confirmed staffing was adequate to meet the residents’ needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family. There was sufficient detail in resident files sampled to identify residents' ongoing care history and activities.  Staff could describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.  Entries were legible, dated and signed by the relevant staff and included their designation in files sampled. Resident files are protected from unauthorised access.  Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files include medical care interventions. Medication charts are in a separate folder and the accident /incident forms were not located on files (refer to 1.2.4.3). |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | PA Low | Residents are assessed prior to entry to the service by the needs assessment team and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed does not include all the requirements of the ARC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer /discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. |
| 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 Moderate | The service uses individualised medication blister packs which are checked in on delivery. A registered nurse and medication competent caregiver were observed administering medications correctly. Medications and associated documentation are stored safely and securely and all medication checks were completed and met requirements. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 10 medication charts reviewed. An annual medication administration competency was not evident for all staff administrating medications and medication training had not been conducted for all staff who administer medications.  There is a self-medicating resident’s policy and procedures in place. There were no residents who self-administered medications on the day of the audit. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Medication charts reviewed recorded indication for use of as required medication by the GP. |
| 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 meals at Lawrence Rural Health Centre are prepared and cooked on site. There is a four weekly winter and summer menu which has been reviewed by a dietitian in September 2014. Meals are prepared in a well-appointed kitchen and served to the residents in the dining room. Kitchen staff is trained in safe food handling and food safety procedures are adhered to.  Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which forms the basis of resident goals and objectives. Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues in the files sampled. The registered nurses are completing InterRAI training and the assessment tool was evident in resident files reviewed. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident files included all the required documentation. The long term care plan records the resident’s problem/need, objectives, interventions and evaluation for identified issues. The service has a specific short term care plans for acute needs. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plans sampled were current and interventions reflected the assessments conducted and the identified requirements of the residents. Interviews with staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room was stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use and night use. A wound assessment and wound management plan was in place for one resident with a chronic wound. Specialist wound advice is available from the adjoining medical centre and the DHB wound specialist nurses. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities staff member provides an activities programme over three days each week. The programme is planned monthly with ideas and suggestions discussed with residents at an informal monthly meeting. Residents receive a personal copy of planned monthly activities. A diversional therapy plan was developed for each individual resident based on their assessed needs. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that is used for resident outings and regular respite residents in the community are included in these events. Residents were observed participating in activities on the day of audit. Resident meetings are held three monthly and include a BBQ or social event and provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. A monthly newsletter is provided for residents, families and the local community. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations sampled were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short term care plans are utilised for residents and any changes to the long term care plan are dated and signed. Care plans sampled were evaluated within the required time frames. |
| 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 | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and/ or their family/whanau are involved as appropriate when referral to another service occurs. |
| 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 | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and the sluice room are locked when not in use. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. |
| 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 service displays a current building warrant of fitness which expires on 13 December 2015. Hot water temperatures are monitored. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility for residents, activities and family/whanau visiting. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are two large communal showers and one ensuite bathroom. There were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs. |
| 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 | The resident rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. |
| 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 is a large lounge and dining room, separate dining room, large conservatory and smaller family/whanau room. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents interviewed reported they are able to move around the facility and staff assist them when required. Activities take place in any of the lounges. |
| 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 | Lawrence Rural Health Centre has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all personal clothing is laundered by caregiving staff. Laundry of linen is contracted to an external company that collects and delivers to the facility. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the rooms/facility. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 1997. All staff maintain a current first aid certificate. Fire safety training has been provided. A call bell light over each door and a panel in the nurses’ station alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources are available. A generator is set up to automatically start if there is a power failure. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks are conducted each night by staff. |
| 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 and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is linked into the incident reporting system. A registered nurse is the designated infection control nurse. Infection control matters are discussed at the monthly staff meetings. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. 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 are adequate resources to implement the infection control programme at Lawrence Rural Health Centre. The infection control (IC) nurse has maintained her practice by attending infection control updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| 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 comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, training and education of staff. The policies are reviewed and updated regularly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse and external providers. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and will be advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014. |
| 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 | Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly facility infection summary and staff are informed. The data is monitored and evaluated monthly and annually by the facility. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There was no recorded restraint or enabler use. Policy identified that if enablers were to be used these will be voluntary and the least restrictive option to maintain independence, safety and comfort. Staff demonstrated knowledge of restraint and enablers and confirmed none were in use at audit. No restraints or enablers were observed to be in use. |

# 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 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Review of the internal audit programme provided evidence all areas of service delivery are monitored. Corrective action plans were not consistently recorded and implemented for identified shortfalls. This was also evidenced in the accident/ incident forms reviewed. There was evidence of medication errors being documented on accident/ incident forms, however the recurrence of the medication errors in January, February and March 2015 did not evidence any documented and implemented corrective action plans. | Corrective action plans were not consistently recorded and implemented for identified shortfalls. | Provide evidence of documentation and implementation of corrective action plans for all identified shortfalls.  180 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Review of accidents/ incidents and the manager’s annual report to the trust evidenced the accidents/incidents reporting process. There was evidence of inconsistent completion of the accident/ incident forms and timely sign off of the forms. The accident / incident forms once written up by staff, are reviewed by the registered nurse are then sent to the manager. The forms were not integrated into the residents’ files and are not accessible to staff. | Accident/ incident forms were not consistently fully completed and signed off in timely manner and the forms were not integrated into residents’ files. | Provide evidence the accident/ incident forms are fully completed and integrated into residents’ files.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The service has documented human resource management systems that are partially implemented. Five staff files reviewed contained interview and application documentation and interview checks. | Staff files reviewed and evidenced there were files that did not evidence orientation documentation (three of five); job description (one of five); no employment contract (one of five). | Provide evidence that the human resource management system is followed.  180 days |
| Criterion 1.3.1.4  Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Low | All residents or their EPOA sign an admission agreement on the day of admission. | The admission agreement does not include all requirements of the ARC contract. | Provide an admission agreement that is current with all legislative requirements.  90 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Medication training was last provided in April 2014. Records evidenced not all staff who administer medicines have completed medication training. There was evidence of medication errors occurring in January, February and March 2015 with no recorded evidence of corrective action (refer to 1.2.3.8).  Medication administration competency is required to be completed annually by all staff who administer medication. There was evidence of the 16 staff who administer medicines, that one RN and two care staff have not completed the required competency assessments. Noting two units standards within the Careerforce qualification include medication ( 23685 pre packaged medications, and 20827 Medication) | Not all staff who administer medicines have conducted medication training and have current medication administration competency. | Ensure all staff that administer medication conduct medication training and have a current competency assessment.  30 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.