

# Clare House Care Limited - Clare House Care

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## 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:** Clare House Care Limited

**Premises audited:** Clare House Care

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

**Dates of audit:** Start date: 15 May 2014 End date: 16 May 2014

**Proposed changes to current services (if any):** Plans are in place for a 28 bed hospital and 18 studios to be built commencing 2015.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 36

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Clare House is a 40 bed facility with separate wings accommodating 20 rest home residents and 20 dementia residents. On the days of this certification audit there were 36 residents, with 18 in each wing.

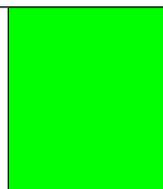
The facility is in Invercargill and owned and operated by a private company. The manager oversees the day to day management of the facility.

The audit process incorporated a document review of policies and procedure and the results of prior certification audits. Onsite sampling was based on the number of residents in occupancy at the time of the audit. This was applied to the number of clinical records viewed, staff interviewed, residents interviewed and the requirements exceeded.. Two resident records were reviewed using tracer methodology – one in the rest home and one in the dementia unit.

No areas for improvement were identified. One area of continuous improvement was identified in recognition of the effective and proactive approach to seeking and addressing areas for quality improvement involving all levels of staff.

## 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.

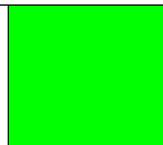
The admission process for residents into the facility is planned and timely. Consent forms are provided prior to admission to ensure residents and families have time to consult with others and are fully informed.

During the audit, staff were observed to respect residents' rights during service delivery, allowing for personal choices, acknowledging and supporting cultural, spiritual, emotional and individual rights and belief and encouraging independence. Residents and family members interviewed reported that staff are very respectful of their needs, that communication is consistent and appropriate and they are given time for discussions to take place with staff and family. They have a clear understanding of their rights and the facility's processes if these are not met.

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was on display at the entrance to the facility and is available on admission in admission packs and on request.

## 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.



Standards applicable to this service fully attained.

Clare House has planned, coordinated and appropriate services in place. A business plan outlining the purpose, values, scope and direction of the facility is reviewed annually and used to drive the quality and risk management system. The owners are

experienced in oversight of aged care facilities. The facility manager has more than 30 years' experience in the health sector and holds a degree in health science. The clinical function is overseen by experienced registered nurses.

The quality and risk system is documented, implemented, monitored, and reflects continuous quality improvement. The system is coordinated and demonstrates monitoring and trending against key components of service delivery. Results of monitoring activities are transferred to a corrective action plan where necessary. Quality improvement activities and projects are proactively pursued, with all levels of staff involved, and have improved standards within the facility; for example, a successful project was used to survey residents' dietary preferences and menu changes were made. The improvement is reflected in the satisfaction expressed in the minutes of residents' meetings. There is a monthly quality meeting with a set agenda to ensure all elements of the quality and risk management system are covered and current. This also addresses infection control, adverse event management and use of restraint. Staff are kept informed through the circulation of meeting minutes.

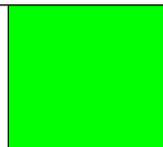
The facility has policies and procedures in place that are aligned to current good practice, legislation and safe service delivery. These are reviewed annually using an effective document control system and are up to date.

Human resources management processes meet current good employment practices and the requirements of legislation. Interviews and reference checks are documented and annual practising certificates, held in the manager's office, are current. An orientation process is documented and recorded for each new employee. Annual performance reviews demonstrated identification of training needs to supplement the extensive in-service training provided at the facility and via the Southern District Health Board. Staff turnover is low with many long serving team members. Staff report a high level of satisfaction with their employment and with staffing levels. Shift rosters demonstrate that the staffing numbers and skill mix policy requirements are met.

Consumer information is uniquely identifiable, accurately recorded, current, confidential and accessible when required.

## 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.

An information package details processes for admission to Clare House. This information explains the need for all rest home residents to be assessed prior to admission.

This facility has nearly fully implemented the interRAI assessment programme. The registered nurse (RN) completes the assessment, from which an individualised, detailed care plan is developed. Regular review occurs to reflect the resident's assessed needs. There has been a comprehensive implementation and review of assessment, care planning and evaluation process with input from residents, families, allied health professionals and the wider community, demonstrating continuous improvement.

Short term care plans are developed when issues arise within the review time frame. Staff were observed providing services in a respectful and dignified manner, reflecting the care plan content. This was also confirmed in resident and family interviews.

The general practitioner (GP) was interviewed during the audit and confirmed the facility provides a high level of care, and assessments and service delivery are appropriate and in line with treatment recommendations.

An activities programme is managed and implemented by two activities co-ordinators, one employed for dementia care and one rest home care, providing a variety of group and individual activities to meet the interests of the residents.

A robotics medication system is implemented and care staff assessed as competent to do so, follow the GP prescription record to administer the medications. The process was observed on the day of the audit demonstrating safe practice occurs. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as changes occur.

## 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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Clare House provides a clean and safe environment. Policies and processes in place protect residents, visitors and service providers from harm as a result of exposure to waste, infectious or hazardous substances. There is separation of clean and dirty linen and appropriate secure storage in place. Personal protective equipment is provided and used by service providers where required.

There is a current building warrant of fitness. Electrical items have been tested for safety. Internal communal areas, bedrooms and hallways are kept clear of equipment and have adequate room for staff to undertake care. External areas are safe and accessible with sensor lights installed and sheltered seating provided. Bathroom areas have non-slip flooring and have room for equipment and carer assistance. Access within the dementia wing is appropriately restricted and monitored to ensure the safety of the residents.

The laundry and cleaning systems are supported by documented policies, procedures and training. Chemicals are stored appropriately and monthly monitoring for effectiveness occurs. Laundry is undertaken on site.

Emergency procedures are in place with emergency supplies, food, water, lighting and cooking facilities regularly monitored. The facility has a battery operated lighting system and a gas supply. An approved fire evacuation plan is supported by fire equipment and smoke alarms. The required evacuation education is provided.

Communal areas, bedrooms and bathrooms are equipped with call bells which are electronically monitored for rapid response.

Security checks are made each night by staff.

All bedrooms and communal rooms have external ventilation. The facility is heated by ceiling heaters which are thermostatically controlled. The facility was at a comfortable temperature.

## 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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The facility does not use physical restraint and demonstrates the use of enablers is actively minimised; the last use of an enabler was September 2011. Enabler minimisation and safe practice processes are documented, monitored, evaluated and reviewed annually. If required at some time in the future it is planned enablers will only introduced after careful assessment, consultation and with due regard to previous episodes (if these have occurred) and use of other alternatives to enablers. The resident and their family/whanau (where appropriate) would be consulted together with the registered nurse and general practitioner and approval is sought prior to any enabler use commencing.

Plans are in place for enabler use to be monitored and outcomes reviewed for consideration of use in the future. The enabler system is well documented and monitored. Staff receive annual education in the safe use of enablers. Restraint minimisation is tabled each month at the quality meeting to assure current awareness is observed.

Environmental restraint occurs in the dementia wing via coded locks on access doors on a permanent basis.

## 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.

There is a documented infection prevention and control (IPC) programme which contains all requirements of the Standards. Policies and procedures guide staff in all areas of infection prevention and control practice. The registered nurse is supported by two enrolled nurses who are also trained in infection prevention and control practices. These three staff form the infection control team, reporting to the manger and the monthly Quality Group meeting. Records sighted and interviews demonstrate this team have a clear understanding of what is required to implement the IPC programme and reporting requirements. The IPC team are able to gain advice from a variety of external sources if required and maintain close links with the Southern DHB. The GP is also consulted regarding individual resident's infections.

Surveillance of infections is occurring and IPC data is collated and analysed with the aim of minimising infections.

All staff receive IPC education on induction and orientation and at least annually. Residents and family/whanau are educated in IPC practices as required for specific practices and when visiting the facility.

## 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)
<b>Standards</b>	0	47	0	0	0	0	0
<b>Criteria</b>	1	95	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Interviews with residents and family (three dementia residents and one dementia family member and three rest home residents and one rest home family member) and a review of records (five dementia and five rest home care) and observation during the audit verified that staff, both in dementia and rest home care, have knowledge and understanding of consumer rights and integrate them into every day practice. Records reviewed confirmed staff training occurs initially during orientation and annually.</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>Informed consent policy and procedures are outlined in policy and are reflected in documentation reviewed. These included signed admission agreements and advance directives, written consents for influenza vaccination, transport, outings, photographs, names on doors and care provision.</p> <p>Staff during interview demonstrated knowledge of informed consent practices. Residents and family confirmed and provide examples that staff gain consent on a daily basis.</p>

<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>	<p>FA</p>	<p>There are policies and procedures that include the right of residents to have an advocate or support person of their choice. Residents and family interviewed confirm that family and support persons are included in discussions relating to care provision. Staff interviewed are aware of the resident's rights to have a support person of their choice at any time.</p>
<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>	<p>FA</p>	<p>All residents and family interviewed verify that family and visitors of their choice are able to visit at any time and there are no restrictions. External community links are encouraged and enabled to continue, with examples of this provided. Care plans and progress notes reviewed confirmed regular outings, activities and appointments where transport can be organised to enable attendance.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A policy which meets the requirements of Right 10 of the Code of Rights is in place for compliments / complaints / concerns.</p> <p>Staff interviewed were clear about the process of receiving a complaint and reporting to management. They stated management was very responsive to any complaint or concern raised.</p> <p>The complaints register was reviewed. This detailed 10 entries over the last 12 months. Seven of the complaints were of a low level and may be viewed as concerns. Of the remaining three complaints, one referred to missing medication. The DHB, Police and Ministry of Health had been advised of this event. New systems have been put in place to improve security and administration recording of 'as required' (PRN) medications. The situation has been resolved. All complaints demonstrated detailed follow through and were well documented. All met the timeframes designated in the policy and met the requirements of the Code of Rights.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family, both in dementia and rest home care, confirmed that they are provided with information regarding the Code of Health and Disability Services Consumers' Rights (the Code), and the Nationwide Health and Disability Advocacy Service prior to admission to the service. They verify that explanations regarding their rights occur initially and on an ongoing basis if they have any concerns. They are aware that an advocate can be appointed if required. None of those interviewed have required the service.</p> <p>Consumer rights posters, consumer rights brochures and information on the Advocacy</p>

		Service were available at the entrance to the facility, and include information on providing feedback, complaints and compliments.
<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>Care plan documents reviewed, in dementia care and rest home care, include preserving independence, values, beliefs and cultural, social, and/or ethnic needs of residents, with further examples observed and provided during interviews with staff.</p> <p>Residents and their family members interviewed have not been subject to, or witnessed, any signs of abuse or neglect. Those interviewed maintain all staff show respect at all times; by knocking before entering rooms, ensuring conversations are private, respecting and understanding the individual resident's values and beliefs and maintaining independence. These practices are observed during the audit and confirmed in the review of residents' files.</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>Currently there are no Maori residents residing in the facility.</p> <p>Policies on cultural safety and Maori health provide guidelines for the provision of culturally safe services for Maori residents. There is ongoing education in line with the Treaty of Waitangi expectations for staff. At initial assessment an appropriate care plan is developed in consultation with the resident and whanau and regularly re-evaluated to ensure it meets the resident's required goals and outcomes.</p> <p>Staff combine the whare tapa wha model of health, the spiritual, mental, physical and extended family commensurate with their needs.</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>Alongside the policy and procedures to address the needs of Maori residents in the cultural safety policy, there is a section on cultural needs of all persons within the facility. Residents and family members interviewed verify that the facility continually ensures their individual values and beliefs are met. Examples are provided that staff ensure residents receive services that respect their individual values and beliefs. This was also observed during the audit.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>Policy documents reviewed, including the elder abuse and neglect prevention policy, include guidelines to ensure residents are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. Staff interviewed demonstrated an awareness of the resident's</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		rights in relation to these areas. Residents and family interviewed verified there have been no issues relating to any coercion or exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Induction and orientation for staff aligns to best practice processes. Records reviewed and interviews with staff verified that in service education and ongoing professional development is provided and supported by the organisation. Policies and procedures are current and reflect good practice guidelines. The facility has implemented the interRAI assessment programme for residents, with eight of the 36 left to complete.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The facility's Open Disclosure policy describes key principles and explains expectations for the service. Residents and family members interviewed confirmed that communication is appropriate and delivered in a manner the resident and family can understand. Staff were observed taking time to ensure when communicating with residents that they are understood and residents have time to answer. The facility's nurse manager has verified the facility has not needed to access interpreter services, although she could explain the processes in place should these be required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The scope and direction of the facility is identified and supported by a philosophy of care relevant to the needs of the residents of the facility. This is reviewed annually. A review of the management system shows strong demonstration of a wide range of goals for care delivery and system monitoring and associated improvement activities.</p> <p>The organisation is managed by an experienced person with authority, accountability and responsibility for the provision of services. She has worked for the facility for 14 years and has been in the current role of manager since August 2014. Her background of 25 years in the health sector includes experience in the roles of caregiver, cook, recreational therapy and management. This is supported by a degree in Health Science. There are registered nurses employed to oversee all aspects of clinical care.</p>
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an	FA	There are registered nurses employed to oversee all aspects of clinical care. During periods of absence, the manager's role is covered by an experienced registered nurse who has been with the organisation for 10 years and who works closely with the operator.

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a comprehensive risk management plan in place which details responsibilities, identification and analysis of risks, and reporting. The plan addresses the risks function. It is supported by a risk register with an area for recording and managing any actions to be taken. This links key components of service delivery. A review of staff and resident meeting minutes demonstrates communication of quality management activities.</p> <p>The quality and risk management system is supported by a Quality Group which meets monthly to measure progress against the quality management plan and risk register and to report on activities. The agenda evidences standing agenda items covering key aspects of quality and risk management. Staff interviewed understood the quality and risk management process.</p> <p>Policies and procedures meet the requirements of the standards and legislation and are reviewed and updated annually. There is evidence of document control with policies notated with most recent review date. Obsolete documentation is segregated to a separate file.</p> <p>Data from quality activity is collected and analysed at the Quality Group meeting. There is a proactive approach to corrective actions which are used as drivers for quality improvements. Minutes are circulated to and signed by those not attending the meeting.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>An incident / accident policy is in place which includes reporting requirements. Adverse events are well documented and staff understood their responsibilities in completing documentation and reporting events.</p> <p>The facility is aware of their essential notification reporting obligations with first contact being with DHB contract manager for advice. The Ministry of Health, Southern DHB and Police are notified as relevant.</p> <p>The facility addresses improvement opportunities via the corrective action plan system.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes</p>	<p>FA</p>	<p>Professional qualifications are validated with current practising certificates sighted for two registered nurses, four enrolled nurses, GPs, pharmacists, podiatrist employed or contracted by the facility.</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>Eight staff files were reviewed and demonstrate safe employment practices are utilised, orientation and performance appraisal occurs and there is a high level of training (eg, all staff have current first aid certificates). There is an annual training programme. The DHB provides access to training which supplements the already comprehensive in house training programme. All caregivers hold an ACE qualification or are currently working towards this and there are financial incentives to complete the programme.</p> <p>Thirteen staff were interviewed and confirmed the high level of training offered and supported by the facility. This is evidenced by records and certificates within the personnel files. Staff reported they felt well trained to meet the requirements of residents within the facility.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A service provision policy is in place and addresses planned service provider skills and staffing levels. Staff interviewed stated they felt the staffing levels were appropriate for safe service provision and felt supported in their roles. A review of the roster showed appropriate staffing levels are maintained.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>A review of records (both dementia and rest home care), interview with the nurse manager and documentation reviewed confirmed that information was entered into each resident's integrated file in a timely manner. Records reviewed were current, accurately recorded, legible and stored in a locked room.</p>
<p>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.</p>	FA	<p>Entry to service documents detail all requirements for both parties on admission to the facility. Records reviewed show a needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions to ensure admission is appropriate. The facility's service agreement requirements have all been met in the files reviewed. Residents and family interviewed verify the facility ensured the admission was timely and carried out with dignity and respect, taking into account the family and resident's identified needs.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>One file of a transferred resident was reviewed. The nurse manager confirmed all transfers and discharges included the involvement of the resident, family and GP. The file reviewed was completed with evidence of family and GP involvement prior to the transfer occurring. Policy reflects the process.</p>

transfer from services.		
<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>Policies and procedures for medication management include each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal.</p> <p>The resident's prescription medication record is completed and updated by the resident's GP and administered by the facility's RN or care staff competent to perform the task. The records reviewed (four dementia and eight rest home records) were legible and each record signed individually by the GP. Prescription records consistently included the reason for pro re nata (PRN) medications. When an alteration occurs the GP updates the record in the facility as sighted in records reviewed. One individual medication profile reviewed demonstrated that a respite resident's medication chart was signed in the incorrect column by a GP and it is recommended that any chart transcribed from a medical centre is checked for correctness prior to administering medication.</p> <p>Two staff members (one carer in dementia area and one carer in the rest home) both with a current medication competency were observed administering medications, demonstrating safe practice on the days of audit. The medications were observed to be locked and securely stored when not in use.</p> <p>The facility has an individual medication profile which includes allergies and sensitivities. Most medication charts had the orange allergy stickers on them once an allergy had been identified; two charts had recently been updated and the allergy sticker not replaced. It is recommended that all medication charts are regularly checked to ensure the allergy identification is not omitted.</p> <p>Verbal orders are not taken in the facility and there is no verbal orders policy.</p> <p>Controlled drugs were reviewed and storage was in line with guidelines and legislative requirements.</p> <p>There was evidence of clinical pharmacy involvement and reconciliation occurring from medication charts reviewed. Discontinued medications are returned to the pharmacy weekly, including controlled medications, as sighted in records sighted by the RN and pharmacist.</p> <p>There was one resident in rest home care reviewed as being suitable to self-medicate medications, complying with the facility's policies and procedures.</p>
Standard 1.3.13: Nutrition, Safe Food, And	FA	A kitchen management policy addressing safe food handling is in place. This addresses areas

<p><b>Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>of procurement, production, preparation, storage, transportation, delivery and disposal. A five week cycle of menus was sighted.</p> <p>Information on identifying additional or modified nutritional requirement guidelines was addressed through a recent external audit of the five week menu plan by a registered dietitian. Changes and recommendations were made and have been implemented as demonstrated by the residents' meeting minutes, menu changes and corrective action activities. Proactive work has been undertaken in this area.</p> <p>Residents are surveyed as to dietary preferences and copies of notes and meal adjustments were sighted as part of the routine practice in the kitchen.</p> <p>Residents are regularly weighed and where necessary, supplements are introduced in conjunction with relevant health checks being undertaken.</p> <p>The kitchen works with an external provider in maintaining kitchen hygiene. Areas inspected were clean and in good repair. Staff were knowledgeable. Food stores inspected were all current and dated. Prepared food was sealed and dated.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>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>	FA	<p>Interview with the nurse manager and a review of records confirmed the facility follows current policy in declining residents that are not suitable for a rest home environment. The nurse manager maintains a record of prospective residents and when a resident is not suitable they are referred to the NASC agency for appropriate placement. The nurse manager provided samples of such situations.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The nurse manager confirmed during interview that prior to admission the NASC agency completes an interRAI assessment to ensure the placement is appropriate, and the nurse manager makes the final decision based on the assessment. The facility RN completed an appropriate assessment on admission to the facility, including a pressure area risk assessment, falls risk assessment, continence assessment, nutritional assessment and if required a wound assessment.</p> <p>An interRAI assessment is completed on new admissions as verified in records reviewed, and an updated care plan is completed based on the completed assessment. Resident, family input and appropriate allied health and community feedback is incorporated into the assessment. Reviews occur in a timely manner by the RN. If an issue arises within the evaluation period, an appropriate assessment tool is completed prior to the development of a</p>

		short term care plan. Examples reviewed showed a consistent assessment and care planning process.
<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 facility's RN develops the initial care plan following an interRAI assessment and within time frames to safely meet the resident's needs. Residents' files reviewed verify the long term plan is completed within three weeks of admission. During interview the nurse manager explained that when progress alters the RN will develop a short term care plan, using appropriate assessment tools. Care staff during interview demonstrated knowledge of the care plan content.</p> <p>Each care plan was complete, comprehensive and included interventions that reflected the resident's outcome goals following the interRAI assessment. Care plans and reviews identify progress toward meeting goals and if required interventions are altered. Residents and family confirmed their involvement in care planning and the review process. There was evidence of allied health interventions in the care plans reviewed and this was confirmed during the GP interview.</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>Policies are in place for continence management; management of challenging behaviours; pain management; personal cares; skin management; wound care; death of a resident; and falls prevention. Links with other services was demonstrated through policies and assessment processes.</p> <p>The facility's RN documents appropriate interventions on the resident's short term or long term care plan, based on completed prior assessments and the interRAI assessment tool.</p> <p>Progress notes are written by care staff and those sighted confirmed residents needs were met and service delivery was provided in a timely manner. This was verified during interviews with residents, family and staff.</p> <p>GP assessments sighted were detailed on the medical clinical forms in the integrated residents' files and the subsequent intervention included on the resident's short term care plans. The GP confirmed interventions were always completed by the facility staff.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	FA	<p>A social activity profile was developed by the activity coordinators in the rest home and dementia unit following admission to the facility in files reviewed. An activity plan was developed following the completion of the resident's long term care plan in both dementia and</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>rest home care. Progress notes were observed to be completed weekly and report on progress relevant to the resident's individual activity programme and social interactions.</p> <p>The general activity programme includes the local shopping run, church services, newspaper reading, arts and crafts, outings, singing group visits, entertainers, sing a longs, exercises, and word games. Residents and family interviewed were very happy with the content and variety of activities provided.</p> <p>The activities co-ordinators are supervised and supported by the Nurse Manage to meet education requirements for their roles as evidenced at audit. An opportunity has been provided from the nurse manager for both activities coordinators to undertake extra advanced training with financial support from the facility.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plan reviews are the responsibility of the RN. During interview the nurse manager reported that when progress is less than expected a short term care plan is developed, and evidence in files confirms this occurs, including re-evaluation and if required transferring the issue to a long term care plan. Examples were sighted where this has occurred. Files reviewed verified care plans were completed at least six monthly as required, and often within three months.</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>	<p>FA</p>	<p>A review of integrated files, resident and family interviews, and one GP interview provided evidence of referral to other health and disability services. During interview with the nurse manager examples were discussed and documentation reviewed of referrals to allied health services.</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>	<p>FA</p>	<p>A policy on waste and hazardous substances management was sighted covering a process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances. Good practice was observed and staff interviewed understood their responsibilities.</p> <p>There is suitable separation of clean and soiled areas in the sluice room, laundry and chemical dispensing area.</p> <p>Caregivers manage infectious waste and are trained in infectious waste and hazardous</p>

		<p>substances management. Staff interviewed demonstrated confidence in the processes used and there is evidence of ongoing training and monitoring of these processes.</p> <p>Protective equipment includes gloves, aprons, goggles, shields, masks and hats. These are colour coded according to area. Staff interviewed confirmed they had received training and this was verified by training records. Use of protective equipment was observed to be correctly used.</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>	FA	<p>A current building warrant of fitness expiring December 2015 was sighted and the hazardous goods certificate is current until August 2016.</p> <p>Corridors were seen to be clear of equipment to ensure ease of movement. Resident's rooms provide sufficient space to allow ease of movement for residents and caregivers. There is sufficient room for any equipment or personal aids. There are safety rails in bathroom areas. Floor surfaces are sound and non-slip.</p> <p>Coded door access is in place in the dementia facility.</p> <p>There are well maintained gardens and external areas. Flat access for internal / external access are in place. The outdoor areas have shelter, furniture, paving, lawns and furniture. There is a sheltered outdoor area for smokers.</p> <p>There are records of extensive checks undertaken against a schedule (e.g. call bells, cleaning, lighting and fittings). The maintenance person has completed electrical test and tag training. Electrical items had current tags. There is a register of electrical test and tagging maintained.</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>	FA	<p>Residents' rooms have a dual access toilet between each two rooms and this includes a hand washing facility. Privacy is assured with lockable doors. There are two showers available in each part of the facility. These include a toilet and hand basin. These are spacious and allow use of equipment and support of one or more caregivers.</p> <p>Separate staff toilet facilities are available. Separate visitor toilet facilities are available.</p> <p>Staff confirmed they have sufficient space to work when assisting residents in their personal hygiene requirements.</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>Residents and support staff are provided with sufficient space to move safely within their personal space and shared areas. There is sufficient room to accommodate and manoeuvre mobility aids. The doorways are wide enough to accommodate equipment. Staff reported they have not had a resident who used a wheelchair in the last 10 months.</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>There is a large communal lounge in each care area. These are supplemented by a further two small lounges in the rest home wing and one small lounge in the dementia wing. There are separate dining facilities in each wing. Activities take place in the dining room and lounge 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>A cleaning, disinfection and sterilising policy is in place. This provides an indication that chemicals will be kept in a secure place. This policy is further supported by a laundry policy. Observation supported staff followed the processes set out in the policies. An externally contracted service provides a monthly monitoring check and records of these checks are kept in the laundry and a report sent each visit. A review of these records did not include any negative findings in the last twelve months. Amendments have been made to the chemicals supplied against the contracted service's recommendations. Chemical management training has occurred.</p> <p>There is a store for cleaning items. Trolleys and mops and chemicals are kept in a locked area which houses the auto chemical dispensers. Chemical safety and use charts were prominently displayed and staff were familiar with the requirements.</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>Fire drills and evacuation training are held for staff and residents twice a year and a report of fire evacuation practice is notified to the Fire Service. Staff training on procedures for fire / earthquakes / power outages / flooding are provided and documented records maintained.</p> <p>An approved evacuation plan dated 1993 was sighted. There have been no changes to service provision since the establishment of this plan.</p> <p>The facility holds a small stock of emergency supplies. Food items were within current use dates. Supplementary items would be obtained from the pantry / refrigerator / freezer if required. There is emergency battery operated lighting. There is a BBQ and gas hobs for boiling of water. Bottled water and torches are in place. Kitchen staff were had clear plans in</p>

		<p>place for utilising any food from the day to day stores if this was accessible. Staff interviewed spoke of community support being in place in the event of an emergency.</p> <p>Each bedroom and bathroom is fitted with a call bell to summon assistance. There are supplementary bells installed in the lounges and dining areas.</p> <p>Security is maintained with exit doors locked at night and hourly checks to ensure security is maintained. External doors are alarmed. The dementia wing has coded locks on main doors / laundry / nurses' station and linen cupboard. The external garden area in the dementia wing has a locked gate for garden equipment access.</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>	FA	<p>Rooms utilised by residents have windows for ventilation and natural light. Each room used by residents has a heating source. There are extractor fans in the kitchen / laundry / bathrooms.</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>	FA	<p>A comprehensive package of policies, procedures and guidelines appropriate to the service, are in place. A registered nurse who works across both wings of the facility, takes responsibility for infection control. She is supported by an enrolled nurse working in each wing. These three staff members interviewed reported they join the Southern DHB one day infection control training programme each year to refresh and further their infection prevention and control knowledge. From this learning, they develop and provide infection control training for all staff. This is evidenced by training records and supported by interviews with staff.</p> <p>The infection control programme is reviewed annually and discussed monthly at the Quality Group meeting. Use of antibiotics is documented for surveillance. The results are graphed and presented at the monthly Quality Group meeting. A quarterly report demonstrated trending and analysis. Areas for improvement are targeted via the corrective action process and addressed via the Quality Group meeting.</p> <p>Staff report there has not been an infectious outbreak in the facility for more than ten years. Residents with colds or other illnesses are encouraged to stay in their rooms. Unwell staff are sent home. There are signs on the entrance doors asking visitors to stay away if they are unwell. Strategies are in place to deal with an infectious outbreak should this occur. This included signage and personal protective equipment to be used in conjunction with established processes.</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>Three staff receive in-depth annual training from the Southern DHB. All staff receive annual in house infection control training including hand hygiene, cleaning, and standard precautions. These three infection control team members were interviewed and were confident in their knowledge of infection control.</p> <p>Staff interviewed confirmed they access the three infection control specialists for advice on any aspect of IPC who provide the necessary oversight to any IPC procedure required.</p> <p>Posters and information sheets are placed where required and staff know how to access the IPC policies and procedures.</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>There are appropriate documented policies and procedures in place for the prevention and control of infection which reflect current accepted good practice and relevant legislative requirements. These are reviewed and updated annually to reflect current good practice.</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>The facility accesses the Southern DHB annual one day infection control refresher training programme and is attended by the three IPC leaders. The knowledge gained at this training is introduced to support and refresh annual training provided in-house to all staff at the facility. Staff interviewed felt confident in their IPC knowledge and practice.</p> <p>Training records evidenced staff receive regular training and updates on IPC matters.</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</p>	FA	<p>There is a surveillance programme in place. This is well documented with the data evaluated, analysed and trended. Reporting occurs at the monthly Quality Group meeting and via a quarterly Infection Control Report. Adverse outcomes are addressed via the corrective action process and documented. All processes are well documented.</p> <p>The infection control leaders determine the surveillance requirements and discuss any</p>

programme.		<p>changing needs for consideration in amending the surveillance programme as required and at time of the annual review.</p> <p>All staff are provided with the results of surveillance and trends via the monthly Quality Group minutes and quarterly reviews.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>A detailed restraint minimisation policy is in place. This is supported with an approved restraint / enabler use guide.</p> <p>A restraint register was sighted. Physical restraint is not used. Environmental restraint is used in the dementia wing with coded locks on doors where required. There has been no use of enablers since September 2011.</p> <p>There is evidence of staff training and staff interviewed spoke confidently about the use of processes should they be required. All processes are in place to address any events that may arise in the future. These processes include evaluation, analysis, trending and reporting functions.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>There are safe systems which meet the requirements of the standard in place to evaluate any episode of restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint is a standing agenda items on the monthly Quality Group meeting agenda. This assists the recognition of use of restraint requirements before the staff. In the event use of restraint is implemented, there are systems in place for monitoring and review.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>There is a proactive approach to corrective actions resulting from audit findings and other activities in the quality management system. A wider group of staff has become involved in the audit function which may result in identifying corrective actions or an opportunity is identified and written up as a corrective action to ensure the improvement is undertaken, monitored, analysed and reported. Corrective actions are well written, detailed and demonstrate adherence to timelines to achieve improvements throughout the facility.</p>	<p>The Quality Group meeting minutes demonstrated a proactive approach to seeking and addressing quality improvement opportunities using the corrective action system as a vehicle for the improvement activities. This has resulted in staff at all levels of the facility being involved in quality activities. One example was the survey of residents on meal preferences. Enhancements to the menu were introduced and satisfaction of the residents with these changes was sighted via the residents' committee meeting minutes.</p>

End of the report.