

# Aspen Lifecare Limited

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Aspen Lifecare Limited
<b>Premises audited:</b>	Aspen
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 6 August 2015 End date: 7 August 2015
<b>Proposed changes to current services (if any):</b>	The use of 26 beds to be used for dual purpose beds so either rest home and/or hospital level of care residents can be admitted to the service.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	30



# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Aspen Lifecare is a privately owned facility which is managed by a nominated management group. Currently it offers care for up to 54 rest home level care residents.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. At the request of the provider this audit is also being used to identify if the requirements are met for the service to extend their services to offer hospital level care. This process is known as a partial provisional audit. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management and staff. One general practitioner was interviewed on the days of audit. Feedback from residents and family/whānau members was positive about the care and services provided.

There are six areas identified for improvement. Two relate to organisational management, three to service delivery, and one to infection prevention and control.

The service can clearly identify that they meet all but one of the requirements of the partial provisional audit to allow hospital care to be provided. The one requirement relates to staff education and is one of the six areas identified for improvement.

## 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 organisation provides services that reflect current accepted good practice. Families and residents interviewed state they are aware of and have access to information around consumer rights including the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information is provided in the information pack for residents, in the main foyer of the service, in residents' bedrooms and is promoted at regular residents and families meetings.

There was one resident who identified as Māori at the time of the audit. The service providers report that there are no known barriers to Māori residents accessing the service. Services are planned to provide and promote individual culture, values and beliefs of each resident. Signed consent forms were sighted in all residents' files reviewed and obtained from residents' family/whānau, enduring power of attorney (EPOA) or appointed guardians, as required

Complaints management is undertaken according to policy to ensure response timeframes are met. At the time of audit there are no outstanding complaints.

## 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.
---	--	---

Aspen Lifecare governing body ensures that business and strategic planning in place covers all aspects of service delivery. Facility management reports are presented to a senior management group weekly who then report to the board quarterly. This information is used to identify how set goals are being met. Day to day management of the facility is undertaken by a facility manager who is a registered nurse. No changes to the management team will be required as a result the intended change to provide hospital level care.

The service has quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, resident and family/whānau satisfaction surveys, incident/accident and infection control data collection and review. Not all corrective planning is documented and this remains as an area for improvement as identified in the previous audit.

The service has recruitment processes, including new staff orientation to meet legislative requirements and reflects current good practice. There has been limited staff education presented in 2015 and this requires improvement to ensure staff have the knowledge and skills to provide hospital level care services.

Staffing levels are maintained to meet contractual requirements. The contingency plan sighted for the increase of staffing required so the service can operate as both a rest home and hospital sets out staffing needs for safe service delivery to occur.

Consumer information is managed in ways that meets the requirements of the Health Records Standard. Archived or obsolete residents' records are being stored safely and securely.

## 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.
--	--	--

An information booklet provides information and identifies services offered within the facility. Senior staff are able to provide information to visitors or potential residents outside of normal working hours.

Residents on admission to the service are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. There is an area requiring improvement around short and long term care plans to ensure adequate documentation and care planning related to the interventions and evaluations of the residents. Residents admitted after the 1st of July 2015 have had no interRAI assessment completed by the service as required.

Residents are reviewed by the general practitioner (GP) on admission and assessed thereafter either monthly or three monthly by their GP depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and this is a team approach.

The activity coordinator provides planned activities meeting the needs of the residents as individuals and in group settings. Families and residents reported that they are encouraged to participate in the activities of the facility and are aware of upcoming events. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit. Staff responsible for medicine management have been assessed as competent.

The onsite kitchen provides and caters for residents, with food available 24 hours of the day, and specific dietary, likes and dislikes catered for. The service has a four week, summer/winter rotating menu which has been developed and approved by a registered dietitian. Residents and family have access to a hot beverages machine. Residents' nutritional requirements are 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.
--	--	--

There are documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances and emergency preparedness. Security processes are appropriate to the level of care offered including the addition of hospital level care.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. Medical and electrical equipment is checked at least annually by an approved provider.

The facilities meet residents' needs with the provision of appropriate furnishings, single occupancy bedrooms, adequate toilet, bathing, handwashing, dining and relaxation areas.

Existing laundry and cleaning services will be reviewed as the number of residents increase and hospital level care residents enter the facility.

Areas have been refurbished to cater for proposed hospital level care residents and this includes 26 bedroom areas, additional lounge/dining and the purchase of new equipment.

The facility is heated by electricity and has good ventilation. The outdoor areas provide suitable furnishings and shade for residents' use.

## 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.
---	--	--

The service has restraint minimisation policy and procedures in place which reflect safe restraint use. Staff undertake bi-annual education related to restraint and understood the requirements should restraint be required. At the time of audit there were no restraints or enablers in use and this was confirmed in documentation and staff interviews.

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

The service has an appropriate infection prevention and control management system. The system is suitable for rest home and hospital level of care. Policies and procedures guide the surveillance of infections; however clinical documentation of infections does not meet the requirements defined in guidelines and protocols. Infection prevention and control is a topic discussed at regular staff meetings. Education has been provided for staff, and when appropriate, the residents.

## 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	39	0	5	1	0	0
Criteria	0	87	0	5	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with information as part of the service’s information pack and a copy of resident’s rights is also displayed on the wall in the main foyer in full view for residents, caregivers and visitors and in each resident’s bedroom.</p> <p>The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. At the time of the audit staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs. Staff education is planned and evidenced on the educational calendar to occur (refer to criterion 1.2.7.5).</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>An informed consent policy is in place. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation. Informed consent is closely linked with the Residents’ Code of Rights and Responsibilities.</p> <p>Resident files evidenced sighted consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advanced directives were signed by the resident. Family/whānau interviewed stated that their relatives were able to make informed choices</p>

		<p>around the care they received and families/whānau were actively encouraged to be involved in their relatives care and decision making. Residents interviewed stated that they were able to make their own choices and felt supported in their individual decision making. Staff interviewed acknowledged the resident's right to receive refuse and withdraw consent for care/services and this was evidenced at the time of audit. Staff demonstrated good knowledge on management of challenging behaviours.</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>	FA	<p>The advocacy policy documents that all residents receiving care within the services facility will have appropriate access to independent advice and support, including access to cultural and spiritual advocate whenever required.</p> <p>Family/whānau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and are encouraged to involve themselves as advocates. This is evidenced in the admission process and documented in multidisciplinary meetings. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client information booklet and resident's admissions agreement and brochures are available in the main foyer of the service. Relevant education for staff is scheduled.</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>	FA	<p>There are no set visiting hours and family/whānau are encouraged to visit. This is confirmed by family/whānau interviewed. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme as confirmed in family/whānau/resident interviews and documentation in resident's activity progress notes and care planning.</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>	FA	<p>Policy acknowledges the right to make a complaint is respected by the service. Complaints are addressed by the facility manager to ensure they are resolved in a fair and efficient way. This was identified in the complaints register sighted. There has been one complaint made by a resident since October 2014, when the current facility manager commenced her role, which is fully resolved.</p> <p>No complaints have been made form external parties and there have been no coroners' inquests since the previous audit.</p> <p>Management explained that the residents hold a monthly meeting and they can voice concerns</p>

		<p>during this meeting if they wish. Minor concern shown in meeting minutes are followed up and reported back to the next meeting. The quality meeting minutes indicated a relative had voiced concerns about the time they had to wait for a staff member at reception. This was not documented in the complaints folder and discussion with the facility manager identified that she contacted the person concerned and they chose not to make this a complaint.</p> <p>Management, resident and family/whānau interviews, confirmed that complaints management was explained during the admission process. Staff verbalised their understanding of the complaints procedures and confirmed that they implemented the complaints process as per policy. Complaints are a standing agenda item for both management and staff meetings as confirmed by meeting minutes sighted.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission.</p> <p>The family/whānau and residents that were interviewed reported that the Code was provided to them as part of the information/admission pack. The Code of Rights and process is also regularly discussed at family/resident meetings. Family/whānau and residents expressed that they were happy with the care at the facility provided by staff.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Family/whānau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the bathroom/toilet doors when in use was noted. The family/whānau interviewed confirmed that they were aware of the different lounges that were available for families and that there were no concerns about privacy.</p> <p>Staff interviewed were aware of resident's different cultural needs and affiliations and were able to express the support individual residents required, however this information was not evidenced in all residents' files reviewed. (Refer to criterion 1.3.5.2)</p> <p>The family/whānau interviewed expressed no concerns in relation to abuse or neglect of residents. The family members reported that staff know their relatives well. This was also evidenced at the time of audit.</p> <p>The monthly activities calendar showed regular planned events that were specific to individual and group needs, including values and beliefs of culture, religion and ethnicity.</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>	<p>FA</p>	<p>Policies acknowledge the services responsibilities in their current support of Māori residents in accordance with the Treaty of Waitangi. Policies include Culture Safety, Death and Dying, Advocacy, and Interpreting Services. The service is committed to identifying the needs of its residents and ensuring that staff are trained and capable of working appropriately with all residents in their care.</p> <p>The nurse manager reported that there are no barriers to Māori accessing the service. At the time of the audit there was one Māori resident. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Māori resident and importance of whānau and their Māori culture. This was also evident in care plans expressing the resident's specific and individual needs in relation to their Māori culture and beliefs. The resident and relatives were not available at the time of audit to be interviewed.</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>	<p>FA</p>	<p>Information is obtained from the resident, and where appropriate and the service has permission, from the resident's family/whānau. The admission process involves the initial assessment and social profile gathering of information which includes the assessing of specific cultural, religious and spiritual beliefs.</p> <p>Education on cultural sensitivity and death and spirituality is planned as part of the services training programme. Families and relatives interviewed were happy with the care provided by those staff that also identify with a different culture and enjoy different cultural days that are organised within the facility.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family/whānau and residents reported that they were very happy with the care provided. The families/whānau expressed no concerns with breaches in professional boundaries, and all reported high satisfaction with the caring, calming and patient manner of the staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice was observed and evidenced in interviews with the manager, registered nurse and health care assistants. Examples include policies and procedures that are linked to evidence-based practice, regular visits by the GP, and links with the local mental health services, dialysis and diabetes services. A gerontological nurse specialist has recently been appointed to the local District Health Board. The facility staff interviewed stated that they will begin referring to this person for additional care advice. The family/whānau and residents</p>

		interviewed expressed high satisfaction with the care delivered.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter on initial contact with the service. At the time of the audit all residents and relatives spoke English and did not require interpreting services.</p> <p>The family/whānau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes and accidents/incident forms.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Aspen Lifecare is privately owned with an elected management company, HIL Harbourside Management Services Limited who oversees the services offered. On the day of audit the quality and compliance manager represented the management company. The service has a current business plan (2014-2015) which identifies the objectives and goals of the service. The business continuity plan identifies known risks and hazards and shows how they are managed. The mission statement and philosophy are included in the information given to all residents as part of the admission process.</p> <p>The facility manager has responsibility for operational matters and reports weekly on occupancy, staffing, environmental issues, financials, quality data and general matters. A senior management group employed by HIL are tasked with oversight of the reporting system to ensure the direction set by the board and regulatory compliance are being met.</p> <p>The facility manager is a registered nurse with a current practising certificate. She has been in her current role since October 2014 with two years previous experience in facility management in aged care. Responsibilities are clearly set out in the facility manager's job description.</p> <p>On the day of audit there were 30 residents all at rest home level of care.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service.</p> <p>Partial provisional audit: No changes are intended to the management group. Planning documents sighted includes how the intended increase in services to hospital level of care will be safely managed by the organisation.</p>

<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The facility manager role is undertaken by the clinical operations manager (RN) from HIL during a temporary absence. The facility manager reports this has occurred on two occasions when she has been away.</p> <p>Resident and staff interviews confirmed service provision is undertaken in a timely, appropriate and safe manner.</p> <p>Partial provisional audit: The service intends to employ a senior RN who will be able to undertake second in charge responsibilities with the vision of having a clinical manager role once occupancy has increased and includes hospital level care.</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>PA Low</p>	<p>The service implements quality and risk processes, as described in policy, to ensure all aspects of service delivery are monitored. Staff report during interview that they understand quality processes. Quality and risk management systems include internal audits, complaints management, incident and accident reporting, health and safety, and infection control reporting and analysis. The facility manager sends a documented report to the management company weekly and includes information related to key components of service delivery. This data is presented by the senior management group of HIL at board level at least quarterly.</p> <p>All policies and procedures reviewed were up to date, aligned with current good practice and service delivery and meet legislative requirements. This includes identification of the interRAI assessment tool to inform care planning. (Refer comments in 1.3.3.3). Policies are maintained by HIL.</p> <p>Quality data information is collated and analysed. Quality improvements identified are discussed at staff meetings and during handover as confirmed during staff interviews. This process is inconsistently documented. There are no specific corrective action plans in place. Staff meeting minutes identify what actions are to be taken but there is no documented evidence that the corrective actions have been completed.</p> <p>Actual and potential risks are identified and documented in the hazard register. The hazard register identifies all known hazards and shows the actions put in place to minimise, isolate or eliminate risks. The facility manager confirms that any newly found hazards would be shown via use of the hazard awareness form and would be communicated to staff and residents as appropriate. No new hazards have been identified since the facility manager has been in her role. Staff confirmed that they understood and implemented documented hazard identification processes.</p>

		Partial provisional audit: Lack of documentation of corrective actions was identified in the previous audit and remains unmet.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Policy is implemented to ensure all adverse, unplanned or untoward events are systematically recorded and reported. Incident and accident forms reviewed identified that family/whānau are notified to reflect the principles of open disclosure. This is confirmed during family/whānau interviews.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Documentation of corrective actions could not all be located. (Refer comment in criteria 1.2.3.8.)</p> <p>The facility manager understands the statutory and regulatory obligations in relation to essential notification to the correct authority.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Staff files reviewed identified that good human resources management processes occur. They reflect good employment practice and meet the requirements of legislation. Upon employment, referees are checked and job descriptions clearly describe staff responsibilities. Management confirm that this practice will continue for all newly appointed staff including the additional staff required to cater for hospital level care residents.</p> <p>Staff have completed an orientation programme with specific competencies for their roles, some of which are repeated annually, such as medication management competencies. One of 12 staff members interviewed felt they would have a better understanding of their role if a longer orientation had occurred. This information was passed onto management at the time of audit. Some staff are employed on short term contracts from another nearby facility who also use HIL services. This ensures the staff are familiar with policies and procedures.</p> <p>The service annual education calendar requirements have not been completed to date. Staff report the education they have received is appropriate to the roles they undertake.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. Volunteer staff have job descriptions and have undertaken appropriate human resources processes and education for the roles they are involved in.</p>

		<p>Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results which gained a 91% overall rating, identified that residents' needs are met by the service.</p> <p>Partial provisional audit: Staff education needs to be undertaken as shown in the education calendar to ensure staff knowledge and skills allows them to provide services that include hospital level care residents. Other aspects of human resource management meet the needs of new staff employment requirements.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A review of three weeks of rosters showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents' interviewed stated all their needs have been met in a timely manner. The quality and compliance manager stated that rosters are based on recognised standards for safe aged-care and dementia care.</p> <p>All shifts are covered by a staff member who holds a current first aid certificate. Clinical care is overseen by a registered nurse (RN). Documentation identifies that a RN is on call at all times.</p> <p>The activities coordinator works Monday to Friday. There are dedicated kitchen, laundry and cleaning staff.</p> <p>Partial provisional audit: A transition plan was sighted which is to be used by the service to predict the staffing numbers and increase of hours required as the number of hospital level residents occur once this has been approved by the Ministry of Health. The predictions shown match the requirements of safe aged care indicators for hospital level DHB contractual requirements which include 24 hour RN cover.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name and date of birth and national health index (NHI) number are used as the unique identifier on all residents' information sighted. Clinical notes reviewed were current and accessible to all clinical staff in an integrated file. On the day of admission all relevant information is entered into the resident's file by the registered nurse following an initial assessment and the doctor when he visits.</p> <p>The files were being kept secure and only accessible to authorised people. No personal or private resident information was observed to be on public display during the days of the audit.</p> <p>Archived records were being safely held on site for ten years. These are catalogued for easy retrieval.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>A computer based system folder holds a record of enquiries. The resident admission agreement is based on the Aged Care Association agreement which is individualised to the service. The residents' records reviewed have signed admission agreements by the resident/family and/or EPOA.</p> <p>Vacancies are updated daily through Eldernet and Aspen Lifecare also has their own web site. The entry criteria sighted and the service's website clearly identifies what services are provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. The form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, process when an error occurs as well as definitions for 'over the counter' medications that may be required by residents. The sighted policies meet the legislative requirements and best practice guidelines.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of the audit. Medicines were stored in a locked medicine trolley and stored in a locked room.</p> <p>The 12 medicine charts reviewed have been reviewed by the GP every three months as was recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. All the medicine files reviewed have a photo of the resident to assist with the</p>

		<p>identification of the resident. The controlled medicines register was sighted and all controlled drugs currently stored on sight are in use.</p> <p>Two residents self-administer medications and documentation and assessment of the resident's ability was evidenced and was reviewed every three months by the registered nurse and GP. The resident's medication is locked in a drawer in the resident's room.</p> <p>There are documented competencies sighted for the staff (registered nurse and caregivers) designated as responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. The medicine competencies undertaken by current staff include specific insulin and warfarin instructions.</p> <p>Current medications that require to be refrigerated are correctly stored and the registered nurse is responsible for the recording of temperatures. All temperatures were maintained within the recommended range.</p> <p>Partial provisional audit: The newly upgraded nurses' station for the proposed hospital wing has a locked controlled medicine safe. There was evidence of planned storage for the medication system to be stored on the shelving provided. Oxygen bottles were stored appropriately. Competencies cover the requirements for residents who are hospital level care.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And 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>FA</p>	<p>The kitchen standard operating procedures sighted, cover aspects of food procurement, production, storage, transportation, delivery and disposal and comply with current legislation and guidelines.</p> <p>There is a kitchen and food policy that states that food handling areas and practices will meet the requirements of the Food Act 1981. It includes guidelines for cleaning with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safety requirements. Kitchen staff have undertaken appropriate food safety management education.</p> <p>There is a four week rotating menu with summer and winter variations. The menu is created and reviewed by a dietitian. Where unintentional weight loss for a resident is recorded, this is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the registered nurse upon entry to the</p>

		<p>service and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. Residents supported by speech and language therapists and plans were also evidenced around resident and food safety. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal, with resident's having the option of trays in their rooms. Family/whānau and residents interviewed reported that they are very satisfied with the food and fluid services.</p> <p>Partial provisional audit: The kitchen is equipped to cater for up to 54 residents as no new rooms have been added. The cook confirms all types of dietary requirements can be met. The menu review states it is suitable for aged care. The service will ensure all food standards are maintained and that food temperatures are monitored in the newly developed kitchenette area located in the refurbished wing to be used for hospital level care. Equipment will be purchased to ensure food delivery is appropriate.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</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>	<p>FA</p>	<p>The administrator and manager interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. If the service can no longer meet the needs of a resident the resident agreement has a clause on when the agreement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>The service continues to use organisational paper based assessment tools and associated care plans. The residents' files reviewed have assessment information that is obtained from previous caregivers, services and, where applicable, the resident's family or nominated representative. Assessments are carried out by a registered nurse and include falls, skin integrity, challenging behaviour, nutritional needs, continence, communication, end of life requirements, self-medication and pain and oral hygiene assessments. Where a need is identified, interventions for this are recorded on the care plan and expert assistance, such as mental health services, are requested as required. However assessment tools are not always</p>

		completed. Management confirm that one interRAI assessment has been undertaken.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The service has care plans in place however the six residents' files reviewed did not address the resident's current abilities, concerns, routines, habits and level of independence. Not all strategies for reducing and minimising risk while promoting quality of life and independence were sighted in the reviewed residents' files and not all the care plans sighted evidenced the required interventions to allow individualised continuity of care.</p> <p>The caregivers interviewed demonstrated knowledge about the individual residents they care for and their needs.</p> <p>Diversional therapy care plans reviewed demonstrated that the resident's individual diversional, motivational and recreational requirements are managed. The files reviewed showed input from registered nurses, care and activities staff, medical and allied health services.</p> <p>The families/whānau interviewed reported they were very happy with the quality of care provided by the service</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>In the files reviewed there was documented evidence that the interventions identified on resident care plans are undertaken by staff. Refer to comments in criterion 1.3.5.2 related to not all interventions being identified on care plans.</p> <p>Staff interviews confirmed all staff deliver services to meet residents' needs and wants. This is supported during resident, family/whānau and GP interviews. The clinical staff interviewed reported they are informed of any care changes required at hand over and in the communication book.</p> <p>Residents' report all their needs are met by the service provided.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme uses a framework to empower the residents to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activity coordinator adapts activities to meet the needs and choices of the resident.</p> <p>The daily and monthly activities plan sighted was developed based on the residents' needs, interests, skills and strengths. The daily plan is written on the board in the main dining room</p>

		<p>and a monthly calendar is delivered to each resident in their room and different activities discussed that may be of interest to them specifically.</p> <p>The activities programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on sensory activities and reminiscence and events that are organised within the township. Regular activities include the reading and discussing of current affairs, different church services, daily exercise, Van outings, specific women's and men's groups, arts and crafts, 'happy hour' once a month and regular weekly entertainment.</p> <p>The service provides easy access to outside areas that enable the resident to wander safely. There are tactile objects and plants in the outside areas with several of the residents having their own garden areas which they maintain.</p> <p>Residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period. The goals are updated and evaluated in each resident's file three monthly. The family/whānau interviewed reported that their relative enjoys the range and variety of planned activities.</p> <p>The facility has one activities coordinator who works full-time Monday to Friday 8.30 am – 3.30 pm and a second staff member who oversees activities on the weekend; both are supported by a group of four community volunteers. The activity coordinator has recently attended training and attends a two monthly community diversional therapy meeting.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Staff interviewed were able to express the residents support required and interventions and evaluations that had occurred but this is not evidenced in documentation thus does not meet DHB contractual requirement. Of the six residents' files reviewed evidenced three residents' care plan evaluations were not complete. Family/whānau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition. Evaluations were an area identified for improvement in the previous audit and this remains open.</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</p>	<p>FA</p>	<p>Residents are provided with options if required to access other health and disability services (e.g. public or private). There is one GP who visits the service on a monthly basis and will visit more frequently to see a resident as and when required. The GP will arrange for any referral to specialist medical services in consultation with the registered staff when it is necessary. The registered nurse interviewed reported that referral services respond promptly to referrals sent.</p>

<p>providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>Records of the process are maintained as confirmed in all residents' files reviewed, which included referrals and consultations with the mental health services, general medicine services, psychiatrist, radiology, podiatry, speech and language therapist and dietitian. The GP interviewed reported that appropriate referrals to other health and disability services are well managed at the service and no concerns are noted.</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>The safe management of waste and hazardous substances is implemented as described in policy. The processes in place enable residents, visitors and service providers to be protected from harm as a result of exposure to infectious or hazardous substances.</p> <p>Staff confirmed they have access to appropriate protective clothing (PPE) and equipment is described in the health and safety policy. Use of PPE was observed on the days of audit.</p> <p>Partial provisional audit: A new sluice room has been created in the hospital / dual purpose beds area.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation sighted identified that all processes are undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in February 2016. The maintenance person completes all required maintenance of buildings and the grounds to provide residents with a safe environment. A regular maintenance schedule and established reactive maintenance processes are implemented to ensure newly found issues can be addressed in a timely manner. All areas sighted were well maintained.</p> <p>Electrical safety testing occurs annually and was last undertaken in July 2015. Clinical equipment is tested and calibrated by an approved provider at least annually or when required as evidenced in documentation sighted. The care facility lift is checked annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, there are secure handrails in corridors, bathroom floors are non-slip, and the safe use of mobility aids is promoted by ensuring the walking areas are clutter free. Environmental audits sighted identify that the service actively works to maintain a safe environment for staff and residents.</p> <p>There are easily accessed, level surface, shaded outdoor areas for residents.</p> <p>Partial provisional audit: The areas which are to be used for hospital level care residents have been totally refurbished. Widened doors into bedroom and bathroom areas allow ease of movement for lifting equipment and wheelchairs. The service has purchased 12 hospital electric</p>

		<p>beds and the facility manager has approval for ongoing bed purchases as the facility accepts hospital level residents. There is currently one lifting hoist available with another one on order. Staff report the equipment they have will enable them to manage hospital level care residents in a safe manner. Areas identified for improvement in the previous audit have all been met.</p> <p>Outdoor areas are suitable for hospital level care residents.</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>There are adequate numbers of centrally located toilet/shower facilities in each wing. All bedrooms have hand basins. There are separate visitor and staff toilets. Hot water temperatures sighted identified that regular monitoring of hot water occurs and remains below the required 45oC for safe resident use.</p> <p>Partial provisional audit: The bathrooms in the areas which are to be used for hospital level care residents are large enough to accommodate shower chairs and lifting equipment.</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>	FA	<p>All bedrooms are single occupancy and of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet residents' wants and needs and have appropriate areas for residents to place personal belongings.</p> <p>Partial provisional audit: The 26 bedrooms proposed for hospital level care resident use are large enough to manoeuvre lifting equipment if it is required. The refurbished bedrooms have been completed to a high standard.</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>	FA	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There is a main dining area which is large enough to accommodate all residents.</p> <p>There are also several small seating areas which have attached kitchenettes with tea and coffee making facilities. These smaller lounge areas can be used as quiet areas and there is one dedicated quiet room which is known as the sensory room. The spacious main lounge is the area where the majority of group activities occur. Residents can choose which lounge they wish to use.</p> <p>Residents and family/whānau voiced their satisfaction with the environment.</p> <p>Partial provisional audit: As no additional rooms have been added available spaces are adequate to cater for hospital level care residents. A second dining/lounge area has been</p>

		<p>established to cater for hospital level residents who do not wish to go to the main lounge or dining area. The new dining/lounge area is delineated by the placement of furnishing and flooring. It will be able to accommodate up to 12 residents. The facility is awaiting a hot box for the delivery of food to this area which will be used for some of the newly proposed hospital level care residents.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></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>	FA	<p>Policies and procedures for both cleaning and laundry duties guide staff actions to ensure the facility remains hygienic and assist in the control of infections.</p> <p>Chemicals are securely stored and appropriately labelled. Dedicated cleaning staff maintain the documented daily cleaning schedule Monday to Friday. Weekend cleaning is limited and currently undertaken by the laundry staff for one hour each day. The facility looks and smells clean.</p> <p>There are dedicated laundry staff seven days a week. The washing machines are serviced regularly and washing cycles are checked by the chemical providers. Staff confirmed during interview that they understand what each wash cycle is for and how to manage infectious linen safely.</p> <p>Residents and family/whānau confirmed they are happy with the laundry and cleaning services provided.</p> <p>Partial provisional audit: The service has allowed for an increase in cleaning hours as the number of residents increase. This is identified on the proposed roster changes sighted. The increased volume of laundry for proposed hospital level residents may require an additional washing machine to be purchased and the laundry area is spacious enough to accommodate this. The facility manager stated her awareness of this need and that laundry services would be closely monitored to gauge any changes required.</p>
<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency management policies and procedures implemented guide staff actions in the event of various emergency events. The service reviews and updates their disaster management plan annually. Much of what is in the emergency plan is generic and it was suggested to the facility manager that this may be more useful if it were to be personalised for Aspen Lifecare. Staff attended an emergency planning workshop in June 2015 which was presented by a local DHB representative.</p>

		<p>Emergency supplies and equipment include food and water. The emergency evacuation plan and general principles of evacuation were clearly documented in the fire service approved fire evacuation plan. No changes were made to the building footprint during the upgrade of rooms and the existing evacuation plan dated November 1997 remains applicable. Fire equipment is checked annually by an approved provider. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQs for cooking.</p> <p>Emergency education and training for staff includes six monthly trial evacuations. No follow up actions were noted for the last evacuation which occurred in February 2015. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.</p> <p>A security company undertakes a nightly patrol of the grounds, staff check exterior doors and windows and there is adequate exterior lighting which operates on sensors. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>Call bells are located in all residents' areas so residents can get staff assistance when required. Resident and family/whānau interviewed confirmed call bells were answered in an acceptable timeframe.</p> <p>Partial provisional audit: The service is aware that emergency supplies and equipment must meet the requirements of hospital level care residents. What is currently available is appropriate to meet these requirements. As no new areas were added existing fire requirements meet the needs of hospital level care residents. Newly refurbished bedroom area call bells were tested on the day of audit and an audible sound can be heard throughout the facility with a ceiling light which goes on to guide staff to where the bell has been activated.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All resident areas have at least one opening window for natural ventilation and light. The facility has electric heating throughout with all residents' bedrooms having a wall mounted heater. All areas of the facility were warm on the days of audit.</p> <p>Residents and family/whānau confirmed that the environment is maintained at a suitable temperature throughout the year.</p> <p>Partial provisional audit: All resident areas have natural light, ventilation and appropriate heating. Nothing additional is required to meet the needs of hospital level care residents.</p>
<p>Standard 3.1: Infection control</p>	<p>FA</p>	<p>The service has a documented infection control programme which is reviewed as part of the</p>

<p>management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>annual quality review of the whole programme. The infection control programme minimises the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator is the facility manager and is accountable and responsible for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak then this would be reported immediately to staff and management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, staff communication book, one to one, shift handover and in resident's progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices found at entrances to the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents. Gloves and gowns were observed and found in all showers and toilets. Residents who have infections are encouraged to stay in their rooms if required.</p> <p>Infections and trends are discussed at staff meetings. Infection control is planned on the educational calendar.</p> <p>Partial provisional audit: Existing processes will cover both rest home and proposed hospital level requirements for aged care.</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</p>	<p>FA</p>	<p>The facility manager has the role in infection prevention and control co-ordinator. Infection control and any issues are reported and discussed at staff meetings. External specialist advice on infection prevention and control issues is available and when required, support is sourced from diagnostic services and the GP. Recently an infection control nurse specialist has been appointed to the DHB to support community services. The registered nurses and caregivers interviewed demonstrated good knowledge of infection prevention and control.</p>

needs of the organisation.		
<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>	PA Low	<p>An infection control policy sets out the expectations the service uses to minimise infections. This is supported by an infection control manual and policies and procedures that deal with specific areas including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. They are easily understood and appropriate for service requirements.</p> <p>Staff were observed to be practising good hand hygiene and encouraging residents to wash their hands before meals and after personal cares.</p> <p>Policy requires that specific infection control forms are to be completed when an infection is identified. No forms were sighted.</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 infection prevention and control education is provided by the infection control coordinator and external specialists as required. The infection control coordinator demonstrated knowledge of current accepted good practice in infection prevention and control.</p> <p>The registered nurses and caregivers interviewed demonstrated good knowledge of infection prevention and control. Resident education is conducted as required. Staff interviewed stated that if the resident has cognitive impairment, education with the residents can be difficult, though during personal care delivery residents are prompted with infection control measures, such as hand washing before meals and after toileting.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection coordinator completes a monthly surveillance report which she presents to the owners. The service monitors urinary tract infections, soft tissue, eye, vomiting/diarrhoea, lower and upper respiratory tract infections. The monthly analysis of the infections is discussed in staff meetings to reduce and minimise risk and ensure residents' safety.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134.2008). The organisation's restraint philosophy identifies the service is committed to promoting a restraint free environment and staff are provided with guidelines to enable them to prevent the need for restraint. The facility manager (RN) is the restraint coordinator.</p>

		<p>Enablers are described as the voluntary use of equipment by a resident to assist them in maintaining independence and or safety.</p> <p>At the time of audit the facility is restraint free and no restraints or enablers have been put in place since the previous audit. This is confirmed during management and staff interviews and in the six monthly reviews which are documented. The last review was undertaken in June 2015. A restraint register is available if required.</p>
--	--	---

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	Staff meeting minutes identify that areas of deficit are discussed. Discussion with the facility manager confirms that corrective action planning is undertaken when a deficit is found. Staff report that they are made aware of any corrective actions that are required and this is discussed at staff meetings. The documentation of corrective action planning is inconsistent.	Documentation was not sighted for all corrective actions. The facility manager confirms corrective actions have not been specifically documented and therefore no evidence was available that corrective action follow up was completed.	Provide evidence that corrective action planning is consistently documented to an auditable level to identify how areas identified for improvement are being

implemented.				met.  90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>The education calendar in place for 2015-2016 identifies that all aspects of service delivery are covered. Staff educations included on site education with guest speakers, however many of the education sessions programmed have not been undertaken. The facility manager stated this was because of the renovations which were occurring and the turnover of staff following the sale of the business in September 2014. It is noted that many of the topics which were to have been presented are covered in new staff orientation, such as residents' rights and privacy. Staff interviewed were able to verbalise their knowledge and understanding of safe standards of service delivery to meet residents' needs. Staff are notified of opportunities to attend off-site seminars and training days.</p>	<p>Education has not been presented to match the organisational educational calendar. Limited education has been presented on-site since November 2014 as identified in staff education records.</p>	<p>Provide evidence that the expected education, as shown on the 2015-2016 education calendar, is presented as a minimum to maintain staff knowledge and skills.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service</p>	PA Low	<p>Staff were able to verbally express residents' needs and requirements but this was not always evidenced by appropriate assessment documentation. A review of six resident files was undertaken and shows that the social profile and activities assessment, evaluation and review are undertaken within required timeframes. However not all nursing assessments (initial and ongoing) or long term care plans were completed in their entirety (for example wound assessments) or evaluated within timeframes required to meet DHB contractual requirement. Of the six files reviewed, one had a completed medical and initial nursing assessment but no dates or signatures were evidenced.</p>	<p>One of six resident files did not have any completed assessments and one file had partially completed assessments. Two of the six residents' files reviewed had wounds but no wound care assessments were completed.</p>	<p>Provide evidence that appropriate assessment tools are completed to serve as the basis for service delivery planning.</p> <p>180 days</p>

delivery planning.				
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Staff were able to verbally express residents' needs and requirements but this was not always evidenced by appropriate documentation in the planning process. Not all required interventions were shown on the residents care plan. Two of the six residents' files reviewed had wounds but had no wound assessments (refer comment 1.3.4.2) or wound care plans were completed. Policy states that management of short term health issues such as infections will be identified on short term care plans. None were sighted in the two files reviewed for residents who had been treated for infections.</p>	<p>Not all interventions undertaken are identified in residents' care plans, for example, one resident with a specific religious belief did not have this identified on their care plan, and there are no specific requirements about how this will be managed in the care planning process documentation. No wound care information is shown on the care plans to identify required support and or interventions. One of the six residents' files had a behaviour monitoring chart but the behavioural issues were not identified on the care plan. No short term care plans were sighted for issues such as infections and this does not meet policy requirements.</p>	<p>Provide evidence that care plans describe all the required support and interventions to achieve each resident's desired outcome.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the</p>	PA Moderate	<p>Residents whose health status changes, and/or is not responding to the services/interventions being delivered are discussed with their GP and family/whānau. This is documented in progress notes. Of the six residents' files reviewed, four had a documented evaluation that was conducted within the last six months. However the evaluation process does not always indicated the degree of achievement or response to the interventions that are in place.</p>	<p>The evaluations undertaken are not always completed for all aspects of care and do not always identify the degree of achievement towards meeting set goals.</p>	<p>Provide evidence of care plan evaluations that indicate the degree of achievement toward meeting the goals set.</p> <p>90 days</p>

desired outcome.				
<p>Criterion 3.3.1</p> <p>There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.</p>	PA Low	<p>Policies and procedures for infection control management were reviewed and meet requirements. However resident file reviews show that not all policy and procedure requirements are being met by staff. No short term care plans (refer comment in 1.3.5.2) or specific antibiotic related forms were located in residents files reviewed.</p>	<p>The specific forms required in policy to be completed related to the use/need of antibiotics have not been completed for residents who require them.</p>	<p>Provide evidence that all infection control policies and procedures are implemented.</p> <p>180 days</p>

## Specific results for criterion where a continuous improvement has been recorded

---

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display
--------------------

End of the report.