# Parata Anglican Charitable Trust - Parata Anglican Charitable Trust

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Parata Anglican Charitable Trust

**Premises audited:** Parata Anglican Charitable Trust

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

**Dates of audit:** Start date: 30 July 2015 End date: 31 July 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 23

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Parata Rest Home provides care for up to 26 rest home residents. On the day of audit, there were 23 residents. A governing trust board provides overarching governance to the service, with support provided by a board trustee/administrator. Two experienced registered nurses provide clinical leadership and oversight.

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

The manager is an enrolled nurse with a current practising certificate and has worked at the facility for over 30 years. Residents and family interviewed spoke positively about the standard of care and services provided at Parata.

This audit identified improvements required around implementation of the quality system, the training programme, reference checks for new staff, documentation of progress notes, restraint monitoring documentation, care planning interventions, medication documentation.

## 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 service ensures that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints and concerns have been managed and a complaints register is maintained.

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

The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Education and training has been implemented with an informal plan in place. All employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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. |

The registered nurse is responsible for assessment, care planning and evaluation. Residents and their family participate in the care planning processes. Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. The activities programme reviewed supports the interests, needs and strengths of residents. Individual activities are provided either within group settings or on a one-on-one basis.

Medication competent staff have attended in-service education for medication management. There are policies and procedures around medication administration, review, storage and disposal.

All food is cooked on site. Residents and relatives interviewed confirmed satisfaction with food services. Systems for food procurement, storage and preparation are effective. Food is served at suitable temperatures.

## 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. |

The building has a current warrant of fitness and emergency evacuation plan. On-going maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and either have their own ensuite or share with the adjacent room. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. There was one resident requiring restraint. The service reviews restraint as part of the monthly meetings.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (nurse manager) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There are a suite of infection control policies and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control coordinator uses the information obtained through surveillance, to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 44 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 7 | 3 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Parata has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Three caregivers and one enrolled nurse interviewed were able to describe how they incorporate resident choice into their activities of daily living. Staff receive training around advocacy services that includes the Code, at orientation and as part of in-service programme (link 1.2.7.5). Discussion with five residents and three family members confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their EPOA. The admission agreements are signed on admission. Advanced directives are signed-for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. The caregivers and the registered nurse interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  There were five of five admission agreements sighted.  Discussion with family identify the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with residents confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main entrance.  Discussions with family confirm that the service provides opportunities for the family/EPOA to be involved in decisions.  The resident files include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Discussion with staff and family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives interviewed stated they could visit at any time. The service has open visiting hours.  Interviews with the activities person described how residents are supported and encouraged to remain involved in the community and external groups. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. Complaints forms are visible and easily accessible. There are no complaints registered for this service. Discussion with family and residents confirms that the manager is very proactive with any problems and they all feel there has been no need to raise a complaint.  A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack that includes information about the Code and this is discussed during the admission process with the resident and family. Large print posters of the Code and advocacy information, is displayed in the facility.  The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission.  The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Five residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Resident files are stored out of sight. Staff receive training around abuse and neglect.  The Parata Anglican Charitable Trust philosophy of care is documented in the 'commitment to clients' policy. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities.  Five resident files reviewed, identified that cultural and/or spiritual values and individual preferences are identified on admission and integrated with the residents' care plan. Interviews with residents confirm their values and beliefs are considered.  There are clear instructions provided to residents on entry, regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There are current policies and procedures for the provision of culturally safe care for Māori residents. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness training occurred September 2014.  There is a Māori health plan that includes a description of how they will achieve the requirements set out in ARC A3.1 (a) to (e).  The service has developed links with local iwi. There are currently no Māori residents at Parata rest home. Staff interviewed, were able to describe how they would ensure Māori values and beliefs are met. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Three family members interviewed feel that they are involved in decision making around the care of the resident, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Chaplaincy services are provided to residents as well as weekly church services. The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan.  The service provides a culturally appropriate service by ensuring it understands each resident's preferences.  Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position.  Performance appraisals are conducted and staff receive supervision.  Interviews with one registered nurse, an enrolled nurse, the manager and care staff confirmed an awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies and procedures and associated implementation systems, to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001.  There is an established quality system (link 1.2.3). The care provided to residents was praised by the GP, five residents and three family members.  Interview with caregivers inform they are well supported by the service manager and the registered nurse. After hours on-call for clinical concerns is available via the on-call registered nurse attached to the Gore medical centre. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident. Fifteen resident related incident forms reviewed identify family were notified following a resident incident. The registered nurse and the manager confirm family are kept informed. There is access to an interpreter service.  Non-Subsidised residents are advised in writing, of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.  The residents and family are informed prior to entry, of the scope of services and any items they have to pay that is not covered by the agreement.  There is documented evidence of family notification when their relatives health status changes.  The information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Parata rest home provides care for up to 26 rest home residents. On the day of audit, there were 23 residents. A governing trust board provides overarching governance to the service with support provided by a board trustee/administrator. The manager reports to the administrator who provides the trust board with a two monthly report. Two experienced registered nurses provide clinical leadership and oversight.  There is a documented strategic business plan. There is a 2014 – 2017 quality plan and risk management plan in place (link to 1.2.3.7 for review of plans). The quality plan has clear goals and KPIs.  The quality programme is managed by the manager and RN. The quality team incorporates the administration, the manager, the assistant manager and the registered nurse. The committee meets three monthly to assess, monitor and evaluate care at Parata rest home.  D15.3d: The manager has maintained at least eight hours annually, of professional development activities related to managing a rest home. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence of the manager, the facility is managed by the assistant manager. The manager is an enrolled nurse with a current practising certificate and has worked at the facility for over 30 years. The assistant manager is a previously enrolled nurse, now a senior caregiver and has worked at the facility for over 20 years. There are two registered nurses, a full time and a relief nurse. The service has policies and procedures at a service level and a quality improvement plan that are structured to provide appropriate, safe, quality care to people who use the service including residents that require rest home level care. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | Parata has a documented quality system in place. There is no annual review of the quality programme. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff.  Three monthly quality meetings are held, quality data is collated for infections, accidents and incidents and there is an implemented audit programme in place. Annual staff and resident/relative satisfaction surveys are completed. Shortfalls were identified around the closing of the quality loop and communication of quality data.  D19.3: There is an implemented health and safety and risk management system in place, including policies to guide practice. There is a current hazard register that identifies hazards for each area of work.  D19.2g: Individual fall prevention strategies were in place and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Fifteen resident related accident/incident forms were sampled. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whānau had been notified.  Staff interviewed confirmed that they are provided with feedback on incidents and accidents, however meeting minutes did not reflect a discussion on incident/accident data and outcomes (link 1.2.3.6).  Discussions with the manager, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | The staffing levels policy and procedures requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses and general practitioners is kept. There are human resources policies including recruitment, orientation and staff training and development. Gaps have been identified around reference checking for all new employees and the in-service programme. The service has in place, a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in three recently employed staff members’ files reviewed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is an enrolled nurse manager five days a week and on call and registered nurse cover Monday to Friday. Clinical on call is provided via the nurse practitioners from the GP surgery.  The caregivers, residents and relative interviewed inform there are sufficient staff on duty at all times. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident’s individual record within required timeframes. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration, including records from allied health professionals and specialists involved in the care of the resident.  Entries were legible, dated and signed by the relevant caregiver or registered nurse, including designation. Documentation gaps have been identified around progress notes. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs safely. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | There are policies and procedures in place for safe medicine management that meet legislative requirements. The one resident self-medicating, has a current competency assessment in place. Medications were securely and appropriately stored. The medication folders include a list of specimen signatures. Ten medication charts were reviewed. Medication profiles included photographs and identified allergies. Six of 10 medication charts reviewed evidenced that the GP had reviewed the resident’s medication three monthly. ‘As required’ medication did not have documented indications for use. The service uses four weekly blister packs. Medications are checked on arrival by a registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RN and care workers. The kitchen staff have completed food safety training. The cook follows a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family/whānau members interviewed were very happy with the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to residents, should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident’s health condition in files sampled. Overall care plans reviewed included interventions in support of assessed needs (link 1.3.6.1). The registered nurse has received training in InterRAI. To date, eight resident files have been reviewed using InterRAI. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Initial care plans and long term care plans were completed in all of the residents’ files sampled. There was evidence of changes to the care plan when health status changed. Three of five care plans included interventions to support current needs (link 1.3.6.1). Residents and family members interviewed confirm care delivery and support by staff is consistent with their expectations. Family communication was documented in five out of five files reviewed. There are short term care plans in use for changes in health status (link 1.3.6.1). |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The registered nurse and caregivers follow the care plan and report progress against the plan each shift. Staff have access to sufficient medical supplies (e.g. dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessments, monitoring and wound management plans were in place for seven residents. Interviews and documentation reviewed identified that wounds were appropriately managed. The wounds included one skin tear, one pressure injury, two surgical wounds, one venous ulcer and one blister. Shortfalls in wound care documentation and care planning interventions were noted. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The two activity coordinators are responsible for the planning of the activities programme. Activities are provided in the day centre and one on one input in resident’s rooms when required. The activities are provided by the activity coordinators on Wednesday, Thursday and Friday and by caregivers and volunteers on the other four days. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed monthly. Residents have an initial assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and life events. The programme includes residents being involved within the community with social clubs, churches and other facilities. On or soon after admission, a social history is taken and information from this is added into the long term care plan and this is reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. Parata Home has its own van for transportation. Residents interviewed were very complimentary of the activities provided. The activity coordinators both have a current first aid certificate. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the registered nurses within three weeks of admission. In five out of five files, the long term care plan was evaluated at least six monthly or earlier if there had been a change in health status. There is at least a three monthly review by the GP. There were examples where changes in health status had been documented and evaluated (link 1.3.6.1). Five short term care plans reviewed were evaluated. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurse initiates referrals to nurse specialists and allied health services. Other specialist referrals were made by the GP. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness, which expires on 14 June 2016. Electrical equipment is checked annually. Medical equipment has been calibrated by an authorised technician. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms have ensuite facilities. There are separate toilets for staff and visitors. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include the main lounge, a large sun lounge and a separate dining area. There is also a large area, which is used by day club residents but is accessible to all residents at any time. The communal areas are easily and safely accessible for residents. The outside area is easily accessible and well maintained. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.  The laundry is completed on site by care staff. Residents and relatives interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 1994. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. Fire drills have been conducted six monthly. Civil defence and first aid resources are available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. An appropriate 'call system' is available to summon assistance when required. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Parata rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control nurse, with support from a senior caregiver with an interest in infection prevention. There are monthly reports for infection control but these are not evidenced as discussed in the quality meetings (link to 1.2.3.6). Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The registered nurse at Parata rest home is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending annual infection control. The IC nurse and IC team (comprising all staff), has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There is infection control policy and procedures appropriate to for the size and complexity of the service.  The infection control section of the nursing manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. A review of the previous year's infection control programme has been completed. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Training is facilitated by the infection control nurse with expert support from external providers who provide the service with current and best practice information. All infection control training is documented. Infection control training was last provided in June 2014. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly. There have been no outbreaks. Systems in place are appropriate to the size and complexity of the facility (link 1.2.3.6). |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. The service currently has one resident with bedrails in use and no enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.  Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. This is a new policy dated 2015. Enabler use is voluntary.  Training around restraint minimisation and the management of challenging behaviour is not documented for 2014/15 (link 1.2.5.7). The service has appropriate documents for the safe assessment, planning, monitoring and review of restraint and enablers. The RN is the restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, and the resident’s family. The process includes an assessment, consent and three monthly review through the quality meeting as well as on-going individual review. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes an assessment for residents who require restraint or enabler interventions. These were undertaken by the registered nurse in partnership with the family/whānau, in the one file sampled of a resident with restraint. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the restraint file reviewed, an assessment and consent was fully completed. Consent for the use of restraint was completed with family/whānau involvement. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and with approval processes. The file reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the file reviewed, however, documentation gaps were noted. The service has a restraint and enabler register, which was updated each month. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is to be evaluated by the restraint coordinator (RN) and quality team in conjunction with the resident, their family/whānau and GP. Restraint or enabler use is discussed at the three monthly quality/staff meetings, as part of clinical care and care plan review discussions. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Parata rest home reviews the use of restraint as part of its clinical care and care plan reviews, conducted at the three monthly quality/staff meetings. Any corrective actions identified are actioned through these forums. The restraint approval group (quality team) strives for a no-restraint service. |

# 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)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There is a quality and risk plan in place with clearly stated key performance indicators including reducing falls, skin tears and medication errors by 10% and reducing pressure areas by 5%. Staff interviewed are aware of infection control and health and safety matters. Annual surveys have been collated. Internal audits are completed as per schedule. Shortfalls were identified around the closing of the quality loop and communication of quality data. | (i) Not all internal audits have had corrective actions signed off as completed. (ii) The results of staff survey suggestions for improvement and outcomes of resident relative surveys have not been fed back to the participants and resident meeting do not occur. (iii) The quality meeting minutes state that there are reports for key areas such as incidents and accidents, infection control and health and safety. These reports were not available for sighting and meeting minutes do not document the review and discussion of quality data. | (i) Ensure corrective actions are followed up and signed off as completed; (ii) Ensure staff are aware of the outcomes of internal audits and staff surveys. Ensure outcomes of the annual surveys are fed back to residents/relatives. (iii) Ensure quality meeting minutes reflect the review and discussion of quality data.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | There is a documented quality plan with clearly stated key performance indicators that requires an annual review to measure compliance and comparison against stated goals. | There is no annual review of the quality plan documented. | Ensure that there is a documented annual review of achievement against quality goals and update of quality plan as needed.  60 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The service collects information around Incident and accidents and infection control. A review of the data collection evidences that falls and urinary infections have increased. | Action plans are not developed where risks have been identified (such as high falls and high infections). | Ensure that an action plan is implemented to improve the resident outcomes.  60 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Seven staff files were viewed. All contained employment agreements including signed confidentiality statements. Staff appraisals are up-to-date. | Two new employees do not have reference checks. | Ensure all new employees have documented reference checks.  60 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a documented training programme for 2014 and review of file evidences that training has taken place. | The training programme for 2015 is not formalised, the training that staff report has occurred is not well documented. Gaps in training identified, include Infection control training, pressure area care, restraint minimisation and wound training for registered nurses. | Ensure there is a formal training plan and attendance is documented at training.  90 days |
| Criterion 1.2.9.1  Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | Progress notes are documented where there is a change to resident condition. There are clear polices in place to guide staff. | Progress notes are not consistently documented in a timely manner and the content of progress notes lack appropriate information. Four resident progress notes evidenced that only a signature and designation was in place for over three days, no other information was provided. | Ensure progress notes reflect the care and support provided.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medication is administered from a trolley stored in the medication room. Staff administer medication and were observed to sign for medication after it was administered. | i) Four out of 10 medication charts reviewed did not identify three monthly reviews by the GP. ii) Ten out of 10 medication charts reviewed did not have ‘indications for use’ documented for ‘as required’ medication. | i) Ensure all medication files are reviewed at least three monthly by the GP. ii) Ensure that all ‘as required’ medications have ‘indications for use’ documented.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Medication is administered from a trolley stored in the medication room. Staff administer medication and were observed to sign for medication after it was administered. | The following issues were identified in the sample of medication charts reviewed. (i) A resident with herbal medication prescribed has this in the evening blister pack though it is prescribed for the morning. The resident also self-administers her own supply. (ii) One medication chart has a medication prescribed twice – one is short term with no discontinuation date and one regular with no start date. NB: only one dose is being given to date. (iii) A medication chart has not been updated with medication prescribed via GP prescription note despite the GP having visited and reviewed the medication chart. (iv) Residents with more than one medication chart visible – original and faxed copies. (v) A medication chart with medication prescribed, with no start or end date or times to be given – it is unclear if this eye medication was given. | (i) Ensure all medication is given as prescribed. (ii) Ensure only the current medication chart is visible. (iii) Ensure all medication prescribed via a faxed copy or a GP prescription note is transferred onto the medication chart by the GP as soon as possible. (iv) Ensure all medication has a start date. (v) Ensure that all medication discontinued by GP has an end date documented.  30 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Five of six wounds had short term plans in place. Three of five files reviewed had documented interventions for assessed needs. Caregivers interviewed could describe resident’s current needs. | (i) One resident with a grade one pressure sore did not have documented interventions to prevent further breakdown. (ii) One resident assessed as high falls risk and identified weight loss and another resident also assessed as high falls risk did not have documented interventions or strategies to minimise these risks. (iii) One of six wounds did not have a related short term care plan in place. | Ensure that all residents with changes in assessed needs have documented interventions to support current needs.  60 days |
| Criterion 2.2.3.2  Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation. | PA Low | One resident with bedrail restraint had an up to date care plan reflecting resident needs. There is monitoring form in place that requires two hourly monitoring whist restraint is in use, but this had documented gaps. | One resident with restraint has a monitoring form in place but the monitoring of the resident whist in restraint is not consistently documented. | Ensure documentation reflects that monitoring is completed according to the policy and care plan.  90 days |

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

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

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

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

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

End of the report.