# KVTN Investments Limited

## Introduction

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

The audit has been conducted by Health Audit (NZ) 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:** KVTN Investments Limited

**Premises audited:** Alexandra Rest Home

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

**Dates of audit:** Start date: 2 September 2015 End date: 3 September 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:** 40

# 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

Alexander Rest Home provides rest home level care for up to 45 residents. The service is managed by the two owners/managers and a care manager. The residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Service Standards and the service’s contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There is one area identified that requires improvement relating to an aspect of medicine management.

## 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. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. This information is brought to the attention of residents (where able), and their families on admission to the facility. Residents and family members confirmed their rights were being met, staff were respectful of their needs and communication was appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consent is gained as required. Residents and family members are provided with information prior to giving informed consent and time is provided if any discussions and explanation are required.

Staff receive regular and ongoing training on resident rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents. All aspects of service delivery are consistent with upholding and respecting residents’ rights.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination or abuse and neglect, with these policies are understood by staff.

One of the owners/managers is responsible for the management of complaints 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. |  | Standards applicable to this service fully attained. |

KVTN Investments Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management systems are fully implemented at Alexander Rest Home. Documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the services provided including regular monthly meetings attended by the owners/managers.

The facility is managed by the owners/managers and they are supported by a care manager who is a registered nurse with aged care experience. The care manager is responsible for the oversight of the clinical services in the facility.

Quality and risk management systems are in place. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans are being developed, implemented, monitored and signed off as being completed to address the issue/s that required improvement. Numbers of various clinical indicators, quality and risk issues and discussion of any trends identified are reported back to the owners and staff at the quality and staff meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management. Current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and study days are held several times during the year at another local facility. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The owners/managers, care manager and a registered nurse are rostered on call after hours. All care staff interviewed report there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries into residents’ clinical records is legible.

## 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 low risk. |

Residents’ needs are assessed on admission by the registered nurse. All residents’ files provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted were consistent with these documents in all areas other than for residents who self-administer medication.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

All building and plant comply with legislation with a current building warrant of fitness displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

All residents’ bedrooms provide single accommodation and have ensuites toilets and hand basins. Residents' rooms have adequate personal space provided. There are a number of lounges, dining areas and alcoves available. External areas are available for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry, apart from linen is washed on site and cleaning and laundry systems, including appropriate monitoring systems, are used to evaluate the effectiveness of these services.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 no restraints or enablers in use. Policies and procedures are in place to maintain a restraint free environment.

## Infection prevention and control

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| --- | --- | --- |
| 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 service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control nurse reporting directly to the facility manager who is the owner.

There is an infection prevention and control programme which is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance.

## 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 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | New staff have received education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code) as part of their orientation programme. On-going education on the Code is also provided to all staff. Staff demonstrated a good understanding of the requirements of the Code, outlining how these were then incorporated into their everyday 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 | The informed consent policy guides service providers in relation to informed consent. Resident files evidenced formal, documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for the recent ‘flu’ vaccinations.  There was evidence of advance directives signed by the resident. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff training records. Staff demonstrated their understanding of the advocacy service, with contact details for the service readily available.  Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this, although all stated they would feel comfortable about approaching the facility manager should they have any concerns. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to maintain their community interests and networks, and to visit with their families. The service’s activities programme includes regular outings in the facility’s mobility van and participation in community events. Community groups, different church denominations and entertainers also visit the facility on a regular basis.  The service welcomes visitors, and has unrestricted visiting hours. Family members advised they felt very welcome when they visit. Residents reported they are supported by staff to access health care services outside of the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The owner/manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that included three complaints for 2015 and these were managed appropriately.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes.  The complaints process is readily accessible and/or displayed. Review of quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via the quality and staff meetings.  There have been no investigations by the Ministry of Health, Health and Disability Commissioner, DHB, Coroner, or Accident Compensation Corporation (ACC) since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. The owner/ manager advised this information is discussed with them during the admission process and any questions they may have are answered. Staff are also available to discuss the Code and/or the advocacy service with the individual resident and/or their family at any other time if they require additional information or clarification. Posters of the Code are also displayed at the facility.  Residents and family members were familiar with the Code and the advocacy service. Although none of those interviewed had concerns about any aspect of the services being provided, all stated they would feel comfortable raising issues with any of the staff. |
| 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 | Residents were addressed by their preferred names. Each resident has a private room, which they are encouraged and supported to personalise. Staff were observed knocking on closed doors before entering, and maintaining the privacy and dignity of residents during personal cares. Residents and family members confirmed they were treated respectfully and that the individual needs and preferences of residents was acknowledged and accommodated. The resident and family satisfaction surveys for 2014 and 2015 indicated high resident satisfaction concerning their rights being respected.  The residents’ records included documentation relating to individual cultural, religious and social needs, values and beliefs that had then been incorporated into their individual care plan. The plans also included information on the resident’s abilities, and strategies to maintain/maximise their independence. These plans had been developed in conjunction with the resident and/or their family.  The service’s policy relating to abuse and neglect is understood by staff. Staff gave examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff have received education related to abuse and neglect. Staff employment contracts contain information relating to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has a ‘Maori Health Plan’ that guides staff relating to meeting the needs of residents who identify as Maori. The owner/manager also detailed the networks that have been established locally if additional support is required to support any residents who identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The individual preferences, values and beliefs of residents are included in the care plans reviewed. These plans included detailed interventions to ensure resident’s individual requirements are accommodated. Residents and family members advised they had been consulted about the resident’s individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members stated that residents were free from any type of discrimination or exploitation. The owner/ manager advised that the orientation for new staff included education related to all forms of discrimination and exploitation. Information on this topic is also included in each staff member’s employment contract. The staff orientation programme included information relating to discrimination and there is regular training for all staff on the topic. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local District Health Board (DHB). Clinical policies, which are current and reflect best practice, are available to guide staff in care delivery. The registered nurses are also supported to attend external education sessions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members are recorded in the progress notes. Family members expressed satisfaction with how well they were kept informed about any change to the resident’s condition and their involvement in resident care planning. Resident meetings are held three monthly and minutes were reviewed.  The owner/manager advised that interpreter services are able to be accessed from the interpreter services if required. This information is also provided to residents/families as part of the information/admission pack. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | KVTN Investments Limited is the governing body and is responsible for the service provided at Alexandra Rest Home. The business plan includes a purpose, scope, direction and goals and objectives. There are also documented values, mission statement and a philosophy of care. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.  Monthly quality and staff and three monthly resident meetings are held. Meeting minutes are provided for staff along with graphs of various clinical indicators.  The facility is managed by the two owners/managers. An organisational chart shows the responsibilities of each owner/manager along with reporting lines for staff. The personal files of the owners/managers and clinical manager provided evidence of appropriate ongoing education.  The owners/managers are supported by a care manager/registered nurse (RN) who has been in this role since September 2006 and has worked in the aged care sector as an RN since 2001.  On the first day of audit there were 40 residents assessed as requiring rest home level care. KVTN Investments Limited has contracts with the DHB to provide aged related residential care (rest home); long term support – chronic health conditions and short term residential care. |
| 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 | There are appropriate systems in place to ensure the day-to-day operation of the service continues should the owners/managers be absent. The owners/ managers reported the clinical manager fills in for the owners/managers if they are absent and a registered nurse fills in for the clinical manager. The owners/managers and clinical manager confirmed their responsibility and authority for these roles.  Services provided meet the specific needs of the resident group within the facility. |
| 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. | FA | A quality and risk management plan is used to guide the quality programme and includes goals and objectives.  The resident and family satisfaction surveys for 2014 and 2015 indicated that residents and families were highly satisfied with the services provided.  Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms. Quality improvement data provided evidence that data is being collected, collated, and comprehensively analysed to identify trends and corrective actions developed and evaluated.  Quality/staff/restraint/infection control, and health and safety meetings are held monthly and minutes were reviewed. There was documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff reported that copies of meeting minutes and graphs are available for them to review in the staff room. Observations during the audit confirmed this.  Policies and procedures are relevant to the scope and complexity of the service; reflect current accepted good practice, and reference legislative requirements. Policies and procedures are reviewed by the owners/managers and the clinical manager and are current. Staff confirmed that they are advised of updated policies and that policies and procedures provide appropriate guidance for service delivery.  Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms. |
| 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 | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the owners/managers and clinical manager and signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The clinical manager and registered nurse undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. The clinical manager and care staff reported the clinical manager is called if a resident has an unwitnessed fall when the care manager or the RN are not on duty.  Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting for example health and safety, human resources, infection control.  The owner/manager stated they have reported three essential notifications to the Ministry of Health since the previous audit. |
| 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. | FA | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.  The owners/managers and the clinical manager are responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided by way of two study days with different topics throughout the year and staff are required to attend these days. The study days are provided at another local facility. Other education is also provided at Alexander Rest Home. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Competency assessment questionnaires are current for medication management and restraint. The clinical manager and RN have the required interRAI assessments training and competencies.  All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.  An appraisal schedule is in place and current staff appraisals were in the staff files.  An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided seven days a week, and since the previous audit the RN hours have been increased. On call after hours is provided by the owners/managers the clinical manager and the registered nurse. The minimum number of care staff on duty is during the night and consists of two caregivers.  All staff have a current first aid certificate. Residents and family reported staff provide them with adequate care. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident related information is kept in both hard-copy and electronic files. These files are maintained securely. Electronic files are password protected and can only be accessed by designated staff. Archived material is also kept securely and easily retrievable.  All components of the residents’ records reviewed include the resident’s unique identifier. The clinical records reviewed were well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.  Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes clearly identify the name of the person making the entry. |
| 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 | When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.  Information about the service includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.  Files reviewed contained completed assessments. Signed admission agreements met contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes. |
| 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 Low | The medication management policy is comprehensive and identifies all aspects of medicine management.  A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Controlled drugs are stored in separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.  The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.  The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine charts.  A resident who self-administers their medicines has no documentation in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.  Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident’s medication chart. PRN medication requests include indications for use. |
| 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 | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu (April 2014).  A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, was sighted.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance.  Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.  There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| 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 | An interview with the care manager verified a process exists for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents have their needs identified through a variety of information sources that include: the Needs Assessment and Service Coordination (NASC) agency; other service providers involved with the resident; the resident; family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom or the whanau room with the resident and/or family/whanau present if requested.  Over the next three weeks, the RN undertakes an interRai assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A multidisciplinary assessment is undertaken yearly.  Two RNs are trained in using the interRai and all residents have been assessed using this tool, at the time of audit. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and describes the required support the resident needs to meet their goals and desired outcomes.  Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.  Care plans are evaluated six monthly or more frequently as the resident's condition dictated. Interviews and documentation verified resident and family/whanau involvement. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents is consistent with residents’ needs and desired outcomes.  Residents and family/whanau members expressed satisfaction with the care provided.  There are sufficient supplies of equipment, seen to be available, to meet the residents’ needs. |
| 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 | Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.  A residents’ meeting is held three monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN.  Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occur every six months or as residents’ needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.  A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes. |
| 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 | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| 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 | Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.  Observations provided evidence that hazardous substances are correctly labelled, the containers appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff. For example, gloves, aprons and visors were sighted. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed that expires on the 25 June 2016. Review of documentation provided evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed, the owner/manager interviewed and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current.  There are several external areas available that are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.  Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.  Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. |
| 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 | Bedrooms throughout the facility have a shared wash hand basin and toilet ensuite and one bedroom has a full ensuite. There are adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.  Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. |
| 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 bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely. |
| 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 | Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |
| 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 | Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons.  Linen is contracted out, otherwise all laundry is washed on site. There is a dirty to clean flow provided in the laundry. A laundry person is responsible for the management of laundry. The laundry person described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.  The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described the cleaning processes.  Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available. A sluice is available for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.  Residents and families stated they were satisfied with the cleaning and laundry service. This finding was confirmed during review of the satisfaction surveys. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.  A New Zealand Fire Service letter approving the fire evacuation scheme dated 7 February 2006 was sighted. The last trial evacuation was held on 18 March 2015.  Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.  Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets and cell phones.  There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner. |
| 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 | Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.  Areas outside the building are available for both residents and staff who smoke. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme.  The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices.  The infection control practices are guided by the infection control manual, with assistance from the DHB infection control nurse where needed.  It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined. |
| 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 infection control nurse (ICN) is responsible for implementing the infection control programme, and reports directly to the facility manager. A position description is included in the infection control (IC) programme.  The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the ICN attends regular ongoing training. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control programme includes and policies and procedures which are current and signed off by ICPN.  Staff interviewed verified knowledge of infection control policies. Staff were observed to be compliant with generalised infection control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.  Resident education occurs in a manner that recognises and meets the residents’ and the families’ communication style, as verified by resident and family interviews. |
| 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 | In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. These are collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality and staff meetings every month and any necessary corrective actions discussed, as evidenced by meeting records, infection control records and staff interviews. Any immediate action required is presented to staff at hand over. Incidents of infections are graphed and on display in the staff room. A comparison of previous infection rates is used to analyse the effectiveness of the programme. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service does not use restraints. The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134.2008). It states that the service refrains from the use of restraints. The service had no restraints or enablers in use at the time of audit as evidenced by observation, documentation and interview. The services policy was understood by all clinical staff interviewed and annual education related to restraint is a mandatory attendance topic. The restraint co-ordinator is the care manager, and the restraint committee meets every six months as evidenced by meeting minutes. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Policies are in place to facilitate residents’ safely in self -administering their own medications. A resident who self -administers medication had no documentation in place to verify their competency to do so, nor verify acknowledgement of the responsibilities associated with self -administration of their own medicines.  On the day of audit documentation was provided by the GP to verify the resident’s competence and by the resident to acknowledge responsibilities for safe self-administration. For this reason it is rated as low risk however ongoing review of competence is required | Residents are not facilitated to self-administer medication safely. | Demonstrate that appropriate documentation is in place to verify residents’ initial and ongoing competence to administer medication, and acknowledgement of responsibility by the resident for safe self-administration.  .  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.

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End of the report.