# Heritage Lifecatre Limited - Chateau Village

## Introduction

This report records the results of a Provisional 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:** Heritage Lifecare Limited

**Premises audited:** Chateau Village

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

**Dates of audit:** Start date: 23 September 2015 End date: 24 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:** 38

# 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

Chateau Village is situated in Balclutha and is certified to provide rest home, hospital and dementia level care for up to 72 residents. On the day of audit, there were 38 residents. An experienced registered nurse currently manages the service. A charge nurse, and a team of registered and enrolled nurses and care staff support the manager. The quality management system in place is designed to identify opportunities for improvement. Food service and activities continue to be provided to a high standard and residents and families interviewed were complimentary of the service that they receive. Staff turnover is reported as low.

A provisional audit was conducted to assess a prospective new owner of Chateau Village and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. A representative from the prospective owners was also interviewed.

The audit has identified that improvements are required around timeframes for medical admissions, aspects of medication management, the secure unit outdoor environment, repairs to the internal environment and ensuring that privacy is maintained in all communal toilet facilities.

## Consumer rights

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| --- | --- | --- |
| 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 staff at Chateau Village strives to ensure that care is provided in a way that focuses on the individual, and residents' autonomy is valued. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed, evidence informed consent is obtained. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. 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. |  | Standards applicable to this service fully attained. |

The current ownership structure includes a family trust. A representative for the prospective owners was interviewed to establish preparedness in owning and operating Chateau Village. This person has worked in the aged care sector for 25 years and has experience in auditing of quality systems. The prospective provider owns other aged care residential facilities. The current quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are implemented, followed through and communicated to staff. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Discussions with families identified that they are fully informed of changes in health status. Staff advised that there is a comprehensive orientation programme, which provides new staff with relevant information for safe work practice. In-service education that exceeds eight hours annually and covers relevant aspects of care and support, has been provided. Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Advised there are no immediate plans to alter rosters, staffing levels, and policies and procedures following transition to new ownership.

## Continuum of service delivery

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| --- | --- | --- |
| 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 nurses are responsible for each stage of service provision at Chateau Village. InterRAI and additional assessment tools are being utilised. Referral to other health and disability services occur as required. Service delivery plans are comprehensive and demonstrate service integration. Interventions are current and achievements against the identified goals, well documented and linked to the InterRAI assessments. The service uses electronic care planning and progress reporting system. Care plan reviews occurs at least six monthly. Families and residents interviewed are very supportive of the care provided and their needs are met. Three activities coordinators provide a range of activities that are suitable for rest home, dementia and hospital residents. There are policies and procedures to guide staff in the safe implementation of all medicine management system. Nutrition and safe food systems are appropriately managed on site.

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

There is a current building certificate. Furniture and fittings are selected with consideration to residents’ abilities and functioning. Furniture is appropriate to the setting and arranged to enable residents to mobilise. The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals have labels and there is appropriate protective equipment and clothing for staff. The service has effective policies in place for the management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. The service has implemented policies and procedures for fire, civil defence and other emergencies. There is staff on duty with a current first aid certificate. General living areas and resident rooms are appropriately heated and ventilated. Residents’ rooms have access to natural light and there is adequate external light in communal areas.

## 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. |

There is restraint minimisation and safe practice policies applicable to the service. The policy includes enabler and restraint procedures, assessment guidelines, timeframes, monitoring, observation, evaluation and review. Guidelines for the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. The restraint and enabler register is up to date. There are currently no residents using restraint/enablers in the rest home or in the dementia unit. In the hospital, there are two enablers in the form of bedrails. There are five residents using restraint, which includes three residents using bedrail and lab belt/vest, one resident using bedrails and one resident using lap belt/vest.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation, and as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. An outbreak in December 2014 was appropriately reported and managed.

## 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 | 46 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 4 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (three caregivers, two activities coordinators, four enrolled nurses, one registered nurse, one charge nurse and one manager) confirm their familiarity with the Code. Interviews with ten residents (eight rest home and two hospital) and four relatives (two rest home, one hospital and one dementia), confirm the services being provided are in line with the Code of rights.  Code of rights and advocacy training is provided as a regular in-service education and training topic. On interview, the prospective owners’ representative confirmed familiarity with the Code. |
| 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 service has an informed choice and consent form, which is explained by the registered nurse on admission and implemented. Staff receive training around informed consent. Discussions with staff and management confirmed that consents are sought in the delivery of personal cares. Resident and family interviews confirmed that residents were able to make choices. Residents deemed competent by their GP sign advanced directives to make a decision around resuscitation. Admission agreements were signed in the sample of files reviewed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents’ meetings discuss previous meeting minutes and actions taken (if any), before addressing new items. The residents’ files include information on residents’ family/whānau and chosen social networks. Residents receive a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions. |
| 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 | The resident information pack informs visiting can occur at any reasonable time. Interviews with residents and relatives confirm that visiting can occur at any time. Family members were observed visiting on the day of the audit. Key people involved in the resident’s life are documented in the care plans.  Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Chateau Village staff support ongoing access to community and entertainers are invited to perform at the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedures is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.  Information on the complaint forms includes the contact details for the Health and Disability Advocacy Service.  Interviews with residents and relatives indicate they are familiar with the complaints procedure and state any concerns or issues are addressed.  The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. Complaints for 2014 and 2015 were reviewed, including a complaint forwarded from the DHB. A full investigation of all complaints has been conducted and resolutions obtained, which included staff performance management as required. Complainants are advised in writing of the outcome of the investigation, within the required timeframes. Resident meetings are an open forum for residents to air any concerns or issues, which are then dealt with in a timely manner. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identify they are well informed about the code of rights. The manager and charge nurse provide an open-door policy for concerns or complaints. Resident meetings have been held, providing the opportunity to raise concerns in a group setting. A resident satisfaction survey has been conducted. The survey includes questions relating to complaints process and residents rights, with respondents reporting they were overall satisfied or very satisfied.  Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. House rules and a code of conduct is signed by staff at commencement of employment.  The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful. Residents’ files include their cultural and/or spiritual values. Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Staff education and training on abuse and neglect has been provided. Communal/public toilet facilities require privacy locks (link #1.4.3.1). |
| 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 is a Māori heath plan and an individual’s values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. There is information and websites provided within the Māori health plan, for quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training has been provided. |
| 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 | Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives feel they are consulted and kept informed. Family involvement is encouraged (e.g., invitations to residents meetings and facility functions). The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process, as reported by the registered nurse. Care plans reviewed include 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 | The staff employment process includes the signing of house rules and a Chateau Village code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries, evidenced in interview with the manager. Interviews with staff confirm their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The quality programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The recent resident satisfaction survey reflects high levels of satisfaction with the services received. The quality coordinator has been responsible for coordinating the internal audit programme. Policies and procedures have been reviewed. These are available in hard copy. There are staff meetings and residents meetings conducted.  Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they are well supported by the manager. There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies are in place relating to open disclosure. Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures.  A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member’s health status. The manager and registered nurses were able to identify the processes that are in place to support family by keeping them informed. Non-Subsidised residents are advised in writing, of their eligibility and the process to become a subsidised resident should they wish to do so.  Residents and family are informed prior to entry of the scope of services and any items they have to pay for, that are not covered by the agreement.  The facility has an interpreter policy to guide staff in accessing interpreter services. The information pack is available in large print and is read to sight-impaired 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 | Chateau Village provides rest home, hospital and dementia specific care to up to 72 residents. There is a 19 bed dementia unit, and rest home and hospital wings. The service has approval for 10 dual purpose beds. On the days of audit there were two dementia residents in the Balmoral unit, 14 rest home residents and 22 hospital residents. One hospital resident was on a palliative care contract. There were no respite residents.  This provisional audit included an interview with a representative for the prospective owners. This person is in the role of quality and compliance manager for the company who are proposing to purchase the facility. The prospective provider owns eight other aged care facilities. At this stage the prospective owner intends to maintain the existing quality management system and policies and procedures. A transition plan has been developed which includes timeframes and responsibilities. The organisation has a strategic plan, a business plan, and an organisational quality and risk management plan.  The prospective provider has a management team at head office who will oversee the running of the facility. The management team includes a general manager, a clinical operations manager and a quality and compliance manager. Senior management meeting are held weekly. The clinical operations manager will spend a week on site during the transition period. The reporting structure will include weekly and monthly reports from the manager to the management services team on issues relating to occupancy, incidents and accidents, complaints, resources, financial matters and staffing. A meeting, including current owners and prospective owners, is planned for mid-October to inform staff, residents and families of the proposed sale. Staffing levels will remain unchanged until a review has been conducted. The management services team will be available to the manager by phone and email at other times. |
| 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 | Currently, in the absence of the facility manager, the charge nurse is in charge, with support from registered nurses and the current owners. The prospective owner’s management team would be available to provide support to the charge nurse following takeover of the business. The facility manager is responsible for the day-to-day functions of the organisation, including overseeing the quality and risk management programme with support from the quality coordinator.  A review of the documentation, policies and procedures and from discussions with staff identifies the service's operational management strategies, and quality and risk programme are in place, to minimise the risk of unwanted events and enhance quality. |
| 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 | The quality management manual includes the business quality risk and management plan and service philosophy. There is an annual review of the quality programme. The prospective owners have a transition plan prepared, as well as an organisational wide strategic plan, a business plan and a quality and risk management plan. The current quality and risk management plan has documented aims and objectives. The current internal audit schedule and internal audits are being completed. Corrective actions have been developed where compliance is less than expected and corrective actions evidence full completion. There are monthly staff meetings, with evidence of discussion of quality outcomes. Management meetings, registered nurse meetings and resident meetings are also held.  A resident and relative survey has been conducted, with respondents advising that overall, they are very satisfied with the care and service they receive. A survey evaluation has been conducted for follow-up and corrective actions required.  The service collects information on resident incidents and accidents as well as staff incidents/accidents. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.  There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.  There is an annual staff training programme implemented that is based around policies and procedures. Staff attendance records are maintained. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.  The quality coordinator and facility manager have been responsible for policy updates. The prospective owners intend to retain the current suite of policies and procedures. There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are implemented. |
| 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 | There is an accidents and incidents reporting policy. The charge nurse investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of accidents/incidents at monthly staff meetings, including actions to minimise recurrence. Either a registered nurse or a caregiver commences accident/incident forms. Timely follow up by a registered nurse is evident in all samples of resident incident forms reviewed. Discussions with the facility manager, charge nurse and prospective quality and compliance manager, confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and family members interviewed stated they are informed of changes in health status and incidents/accidents. Family notification was recorded on incident forms and in progress notes. |
| 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 | There are human resource management policies in place, which includes recruitment and a staff selection process that requires relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses, podiatrist, physiotherapist and general practitioners is kept. The human resources policies also include orientation, staff training and development. Eight staff files were reviewed (one charge nurse, two registered nurses, one cook, one activities coordinator, and three caregivers) and evidence that reference checks are completed before employment is offered. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service.  Discussion with the acting facility manager, quality coordinator, charge nurse and staff confirms that in-service training has been provided. The caregiver training programme has been provided to staff. There is an in-service calendar for 2015. The annual training programme exceeds eight hours annually. The registered nurses attend external training including sessions provided by the local DHB. There are nine care staff who work in the Balmoral dementia unit (four caregivers and five enrolled nurses). Five staff have completed the dementia unit standards (two enrolled nurses and three caregivers). The remaining four staff are currently in the process of completing the course. The unit opened in May 2015. |
| 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 good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The facility manager works full-time, as does the charge nurse. There is at least one registered nurse on duty at all times and two caregivers in the rest home and hospital wings. The dementia unit currently has one staff member on at all times. A registered nurse is rostered on in the dementia unit for at least one day per week. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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 24 hours of entry. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access, by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public are unable to view sensitive resident information. File entries are legible, are dated and signed by the relevant caregiver or registered nurse.  Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| 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 | Entry criteria, assessment and entry screening processes are documented and implemented. The facility manager and the charge nurse communicate with all appropriate referring agencies regarding residents level of care requirements, prior to the residents’ admission. Of the eight resident files reviewed and relatives interviewed, all confirmed relevant and accurate information was available to them prior to admission in relation to entry criteria and processes. Prospective residents are assessed by the needs assessment agency prior to entry to the facility. The admission agreement contains all information covered by the local DHB contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Resident’s files reviewed showed appropriate communications between families and other providers and demonstrated transition, exit, discharge or transfer plans were communicated to all relevant providers, when required. Transition, exit, discharge, or transfer form and letters were located in residents' files. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service uses four weekly blister dose medication packs for all residents at Chateau Village. There is a signed agreement with the supplying pharmacy. The blister packs are checked and reconciled against medication charts upon arrival to the facility and signed off when the check has been completed.  There are three medication trolleys, which are stored securely when not in use. Medication fridge temperatures are monitored daily.  The service has a policy and procedure on residents who wish to self-medicate that includes three monthly assessments by GP of the resident's ongoing ability to safely self-medicate and a resident competency review form. There are currently no residents self-medicating at Chateau Village.  Lunchtime medication round was observed and evidences that staff are signing off, as the dose was administered. Staff education in medicine management was conducted. Sixteen medicine charts were sampled. All 16 charts demonstrated residents' photo identification. Medication reconciliation has been completed on admission by a registered nurse. There are aspects of medication management, which do not align with best practice. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals for Chateau Village residents are prepared and cooked on site. There are two cooks and four cooks assistants. Meals are served directly to the rest home from the bain marie in the kitchen. The hospital and the dementia unit meals are transported on a trolley and are kept warm using heated plates and thermal covers.  There are four weekly rotating summer and winter menus that were approved by a registered dietitian. Registered nurses inform the kitchen regarding residents’ dietary requirements, which include likes and dislikes, modified diets and preferences. The charge nurse and registered nurses interviewed described the process for management of residents with unexplained weight loss or gain, including referral to a dietitian and speech language therapist, as required. The cook is aware of residents who have been identified with weight loss and the resident's individual dietary needs. Document reviewed showed monthly monitoring of individual resident's weight. Care plans include dietary requirements and were reviewed on a regular basis, as part of the care plan review.  Additional snacks are available for residents when the kitchen is closed. Residents interviewed were satisfied with the food service provided and reported their individual preferences are well catered and adequate food and fluids are provided.  Food temperatures, fridge, chiller, freezer temperatures, frozen food temperatures on arrival to the facility are recorded, sighted.  Kitchen services audits were completed. The service provides special equipment such as utensils, lip plates and sipper cups as required.  The kitchen pantry has extra food stores, with enough for three days if required in an emergency, including adequate water supply. |
| 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 charge nurse reported that they have not declined entry to any potential residents who have an appropriate needs assessment. Discussions with the facility manager and the charge nurse confirmed that should a resident be declined service entry, the reason is recorded and communicated to the resident/family/whānau, and referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The Chateau Village uses the InterRAI assessment tool and the charge nurse stated that all residents had InterRAI assessments. The sample of files reviewed evidenced that InterRAI assessments were completed within four days of admission. The InterRAI assessment summary included residents’ cultural needs and these were linked to the care planning. Assessments also included the relevant look-back period, interview with residents, family and other health professionals. Re-assessments were completed at least six monthly or as required. Assessment results were discussed with staff and included in the daily care notes.  In addition to InterRAI, pain assessment tools were utilised for two residents reviewed who were identified as requiring regular pain relief. Behaviour monitoring and assessment tools were also used in the dementia unit and for residents with dementia in the rest home or hospital, for the first three days of entry to the service. This information was utilised in the development of the long-term care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Registered nurses developed residents’ care plans as reviewed, and InterRAI assessments were used in development of the care planning. All care plans were comprehensive and consistent with InterRAI assessments. Residents’ previous health history and medical risk management plans were included in the care plans. Falls prevention, infections, mobility and restraint interventions were more frequently reviewed and new interventions were added in to the care plans.  Residents’ files reviewed were integrated. Progress notes and care planning were maintained in the electronic records. Documentation was maintained in the paper-based files. This system is understood and is well used by all service providers. A multidisciplinary approach to care is evidenced in residents’ files reviewed. Staff communicate during each shift handover. Residents and family members interviewed were happy with the care provided. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The care being provided for rest home, hospital and dementia care were consistent with the needs of the resident, as evidenced through documentation review and interviews with residents and families. Relatives were notified of changes in a resident's condition. The registered nurses initiate a GP or specialist consultation for any changes in resident health status. Staff documents any changes in care/condition of residents in the electronic recording system. The resident records reviewed were individualised and personalised to meet the assessed needs of the residents. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whānau interviewed, reported satisfaction with the care and service delivery.  Wound assessments and wound progress reports were completed for one resident requiring pressure area care. Wound care assessments and monitoring records were completed. Specialist reviews and recommendations were implemented. There were adequate dressing and incontinence supplies sighted on the day of audit. |
| 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 | There are three activities staff who work Monday to Friday and two of these staff have a national qualification in dementia care. One caregiving staff member is working towards obtaining a diversional therapist qualification. The current activities staff are mentoring this staff member. The three activities staff interviewed reported that they modified the programme related to the response and interests received from residents. Resident's capability and cognitive abilities were considered in planning of the activities program. The activities programme covers physical, social, recreational and emotional needs of the residents.  Chateau Village has a van and has access to a community shared mobility van. Activities care plans are integrated with the electronic care plan system and evaluations are completed when care reviews occurred. Residents and families interviewed confirmed that the programme included interests of individuals and points of interest in the community. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans reviewed were evaluated within three weeks of admission. Long-term care plans were evaluated at least six monthly and they were all outcome or goal focused. The InterRAI outcome assessment is being used as part of the evaluation process. The GPs examine residents monthly or if the resident is stable and then at least three monthly. Three monthly medication reviews were evident in 14 out of 16 medication charts (link #1.3.12.1). Where progress was different from expected in the files sampled, the service has responded by initiating changes to the long-term care plan. All eight files reviewed had evidence of changes in the care plan interventions such as falls prevention, wound care, infections, decrease in mobility and challenging behaviour. The residents and family/whānau interviewed reported high satisfaction with the care provided at the service. |
| 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 | Document review showed that appropriate processes were in place to provide choices to residents in accessing or referring to other health and/or disability services. Residents’ files sampled evidence completed referral forms/letters. Resident referral to and from other services is conducted when required (e.g. by the nurse practitioner, physiotherapist, podiatrist, geriatrician and other medical specialists). An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes were implemented. |
| 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 documented processes for the management of waste and hazardous substances and incidents are reported on in a timely manner. Material safety data sheets are available and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The staff orientation process addresses chemical usage, hazard management and the use of material safety data sheets.  There is appropriate protective clothing and equipment used in the management of waste or hazardous substances for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing is provided and used by staff. Hazardous substances are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid or opening. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | Chateau Village has four wings. The dementia unit has 19 beds capacity and the unit is divided into two areas (11 and 9 room capacity). Due to low occupancy the second part of the unit is not in use. The locked door system for the dementia unit has a code of compliance certificate. The system is linked to the emergency door release system so that in the event of a fire, the doors are automatically unlocked.  The building warrant of fitness is current and expires on 5 June 2016. Maintenance books and records were sighted. Medical equipment calibration is conducted by an external provider which included the hoist and the chair scale. Fixtures and fittings are appropriate and meet the needs of the residents. Hazard register is up to date. Hot water temperatures are monitored and recorded monthly by the maintenance person and these were noted to be 45 degrees Celsius or below.  The service has a van, which carries a first aid kit, mobile phone and water for drinking, which is used to transport residents on outings. The van has a current warrant of fitness and vehicle registration. A gardener maintains external areas. All external areas are on level surfaces.  The facility manager, charge nurse and caregivers interviewed confirm that they have access to appropriate equipment and they are competent to use the equipment.  Staff interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Family and residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.  Part of the building is in need of repair and a secured external area requires a walking path and is too small to accommodate 19 residents. |
| 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. | PA Low | There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Two visitor toilets did not have privacy lock. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The residents’ rooms in all three areas are very spacious and appropriate to the needs of the residents. Resident and family interviews confirmed this view. Resident’s rooms are decorated with personal belongings in order to allow the residents to feel at home and have a sense of belonging. Mobility aids can be managed in the rooms, confirmed at the caregivers’ interviews. All double rooms have adequate space to accommodate resident’s mobility needs and safety requirements. |
| 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 | Chateau Village has large lounge/dining areas – two in the rest home and hospital area and one in the dementia unit. There are also informal areas for residents to sit and meet with their family or friends, confirmed at the resident and family interviews and sighted during the tour of the facility. Group entertainment and activities are conducted in any one of the lounges and residents have enough space to mobilise safely. |
| 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 laundry is large with a dirty and clean laundry flow. Laundry and cleaning services were monitored for effectiveness and this was confirmed at the charge nurse interview and at the laundry person interview. Laundry services and cleaning audits were completed. Cleaning chemicals were securely stored in a lockable cupboard. Chemical safety data sheets are kept in the chemical cabinet and the laundry and staff receive training around the use of chemicals. The residents and their family members confirmed they are happy with the management of their laundry. Visual inspection evidences the implementation of cleaning and laundry processes. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency management training is provided to all staff during orientation and induction and as part of their ongoing training programme. Training includes fire drills and emergency evacuation drills at least six monthly. Civil defence resources are available. There is an emergency management manual, and a fire and evacuation manual. An external contractor provides fire system monitoring and maintenance. At least one staff member on every shift holds a first aid certificate.  The New Zealand Fire Service approved the fire evacuation scheme on 5 July 1994.  The facility has emergency lighting and a gas BBQ for alternative cooking. Two large storage containers of water provide a minimum of three litres per person for three days. Emergency food and water supplies are maintained and are sufficient for at least three days. Extra blankets are available.  A call bell system is available in all areas including bedrooms, toilets, bathrooms and communal lounges and dining areas with indicator panels in each hallway.  The building is secured during the hours of darkness and all visitors and contractors to the facility need to ‘sign in’ for identification. Staff on afternoon duty conducts internal security checks. |
| 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 | The facility is heated via a mixture of large heat pumps in the lounge areas and hallways, overhead ceiling heating in the rest home and hospital area and underfloor heating in the dementia unit. The facility is bright and airy and rooms are well ventilated and light. All bedrooms have external windows. On both days of the audit, the indoor temperature was comfortable and resident and staff interviews confirmed that they were pleased with the heating and ventilation system. |
| 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 | Chateau Village 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. It is linked into the incident reporting system. The charge nurse is the designated infection control nurse with support from the facility manager, registered nurses and quality coordinator (infection control team). The IC team meets to review infection control matters. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff. The infection control programme has been reviewed annually. |
| 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 charge nurse at Chateau Village 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 updates. The IC nurse and IC team has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There is infection control policy and procedures appropriate to for the size and complexity of the service. The infection control 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. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. The infection control nurse with support from the IC team facilitates this. All infection control training is documented and a record of attendance is maintained. The IC nurse attends training. Visitors are advised of any outbreaks of infection and are advised not to visit until the outbreak has been resolved. Information is provided to residents and visitors that are appropriate to their needs and this is documented in medical records. Education on hand hygiene and infection control has been provided for staff. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Chateau Village’s infection control manual. Monthly infection data is collected for all infections, based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered into a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at infection control meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. An outbreak in December 2014 was appropriately managed with timely notification to relevant authorities. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is restraint minimisation and safe practice policies applicable to the service. The policy includes enabler and restraint procedures, assessment guidelines, timeframes, monitoring, observation, evaluation and review. Guidelines around the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint register and an enablers register. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. There are currently no residents using restraint/enablers in the rest home or in the dementia unit. In the hospital, there are two enablers in a form of bedrails. There are five residents using restraint, which include three residents using both bedrail and lap belt/vest, one resident using bedrails and one resident using lap belt/vest. |
| 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 | Chateau Village has a structured approval group that includes key relevant people. The charge nurse, who has the role of restraint coordinator, could describe her responsibilities. The policy requires that individual restraint use is required to be approved by the medical practitioner, involve family/whānau and include an assessment with complete care planning. The service seeks input from these people as relevant and appropriate. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Chateau Village completes comprehensive assessments for residents who require restraint or enabler interventions. Restraint assessments are based on information in the comprehensive nursing assessments, care plan, observations of the staff and resident discussions. A challenging behaviour assessment chart is completed and initial assessment for restraint, which includes a risk assessment and cultural issues taken into account. Ongoing consultation with the family/enduring power of attorney (EPOA) is identified. The restraint coordinator, GP, resident and family/EPOA will discuss options before the consent form is signed.  One enabler and two restraint files reviewed showed that assessments and consents were fully completed. Consent for the use of restraint is completed with family/EPOA involvement and a specific consent for enabler/restraint form is used to document approval. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Chateau Village has a restraint and enablers register for the facility that is updated each month by the restraint coordinator. The resident's care plan refers to specific interventions or strategies to try (as appropriate) before use of restraint. The restraint/enabler assessment process is completed for all restraints/enablers. Monitoring requirements were recorded in the resident care plan and progress notes on a daily basis. The incidents and accidents process was used to monitor further risk to residents. Falls risks and behaviour assessments were also completed as part of the comprehensive nursing assessments. Daily care print outs also included restraint use and monitoring requirements.  In the resident’s file reviewed, monitoring forms had been completed. A monthly evaluation of restraint was completed that reviews the restraint used. Management/quality meetings include restraint minimisation. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation is comprehensive and includes the areas identified in a – k. Evaluations have occurred three monthly, in line with the GP review and family/EPOA are included. Two restraint and one enabler file reviewed included evidence of at least three monthly evaluations. More frequent evaluations were also completed and the individual evaluation timeframes are determined by risk levels, otherwise reviewed three monthly. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Chateau Village actively reviews restraint as part of the internal audit programme. The restraint coordinator completed a monthly report and evaluation. Restraint review was completed three monthly as part of the resident care reviews. Restraint governance meetings held six monthly. Staff are educated on restraints and enablers by the charge nurse during the orientation process, this is recorded in the staff files. New staff are educated on the restraints and enablers by the charge nurse during the orientation process, and this is recorded in the staff files. Ongoing training takes place through Chateau Village's education schedule. Audits on restraint are carried out including monitoring staff entries into nursing progress notes to ensure resident restraint usage can be checked which accurately portrays the resident’s need for restraint. |

# 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 1.3.12.1  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 | Registered nurses administer medications in the hospital, and an enrolled nurse or caregivers administer medication in the rest home wing and dementia unit. There is a list of staff competencies maintained in the education folder and all staff administering medications have passed their competency. Sixteen medicine charts were sampled (two dementia unit, 10 hospital and four rest home). All 16 charts had residents' photo identification on them. Medications are stored appropriately and medication rooms were kept locked when it is not in use. The facility continues to work through issues with GPs around medicine prescribing. Medication charts were changed but there are still two different medication chart forms in use. Allergies were documented on 12 charts and three monthly reviews were evident for 14 of 16 charts reviewed. It was noted that insulin is only checked and administered by one person, expired medications were evident in the medication cupboards, and not all medications had been administered and documented as prescribed. | i) Three hospital charts and one rest home chart did not have allergies documented. One hospital file reviewed had allergies noted on the InterRAI assessment form, but medication chart did not have this information. ii) Insulin is only administrated by one staff member with one signature on the insulin signing sheet. iii) Expired medications evident in medication cupboards and had not been returned to the pharmacy. iv) Two different medication charts were in use for one resident. The most up to date medicine chart did not have two items from the previous chart. Discussions with the registered nurse and the charge nurse confirmed that they believe these two items should be on the medication chart, therefore they continue to use both charts. v) Inhalers were not always documented as administered as prescribed. This was evidenced in one rest home and one hospital medication chart. The medicine was charted twice a day and signed six times in 17 days as one times a day, and on one occasion was signed three times a day. The reason for not administering was not recorded. Medication error forms for these were also not completed. vi) In one medicine chart (hospital), discontinued medicines were crossed off and signed by the GPs but it was not dated. vii) One rest home and one hospital medication chart did not have evidence of three monthly medication reviews. | i) Ensure that medicine allergies are documented on the medication charts. ii) Ensure that two staff members complete insulin checks. iii) Ensure that expired medications are returned to the pharmacy. iv) Ensure that only the current medication chart is in use. v) Ensure that inhalers are administrated as prescribed and medication error forms are completed for signing gaps. vi) Ensure that discontinued medications are dated. vii) Ensure that three monthly medication reviews are completed.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Registered nurses develop care plans and they have the responsibility for maintaining and reviewing them. Care plans reviewed were developed in consultation with residents and family/whānau where appropriate. Initial assessments were completed within 24 hours of entry to the service, InterRAI assessments were completed within four days of entry to the service and care plans were developed within 21 days. Care plan evaluations were completed at least six monthly or earlier if care needs changed. This was evident in all eight files reviewed. Medical reviews were completed at least three monthly but more frequent reviews were noted in the resident’s file. Not all residents were seen by a GP within two working days of entry to the service. | One dementia and two hospital residents were not seen by a GP within two working days of entry to the service. | Ensure that residents are seen by a GP within two working days of entry to the service.  180 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | The building has a current warrant of fitness. During a tour of the facility it was noted that there are areas of the facility which require repair. | There is wallpaper and painting damage at the hospital wing corridor and rest home staff office corridor. | Ensure that repairs are completed.  180 days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | There is plenty of external space for rest home and hospital residents. The dementia unit has a small internal courtyard, which can be accessed by staff and residents. The current residents do not wish to utilise this space. Residents are taken outside and on outings, however prefer to remain in doors. | Secured external area is very small and does not have walking path for residents to safely wander. | Ensure that the secure external area has walking path and is large enough to accommodate up to 19 residents.  180 days |
| Criterion 1.4.3.1  There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Low | There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Communal toilets and showers either have locks or have small in use signs on the door indicating if the facility is engaged. Shared ensuite do not have privacy locks but staff and two residents interviewed did not report any privacy concerns. | Two visitors’ toilets do not have a privacy lock. | Ensure visitors’ toilets have privacy locks.  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.