# G&M Wellbeing Limited - Dominion Home

## 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:** G&M Wellbeing Limited

**Premises audited:** Dominion Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 30 September 2015 End date: 30 September 2015

**Proposed changes to current services (if any):** A provisional audit was completed to assess the preparedness of the new owner to purchase the business.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 19

# 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.

## General overview of the audit

Dominion Home rest home is privately owned and operated. The service is certified to provide dementia level of care for up to 29 residents. On the day of the audit, there were 19 residents.

A provisional audit was conducted to assess the prospective new owners of Dominion Home, 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. The prospective owners were also interviewed.

The current investors/business owners employ a facility manager who is an experienced aged care registered nurse/manager. Two part-time registered nurses support her. The prospective owners reported the current policies, systems and care staff will remain in place following the purchase. The current owners will continue to provide support to the new owners/directors over the transition period of four to six weeks. One of the new owners/directors is a registered nurse with a current practicing certificate.

The current investors have completed environmental improvements including re-furnishing of five bedrooms and interior painting of the lounge and corridors.

This audit identified an improvement required around privacy, clinical and food safety policies, wound care documentation, evaluations, medication reviews, food services temperature monitoring, chemical safety and maintenance of toilets/shower areas.

## Consumer rights

Dominion Home provides care that focuses on the individual residents. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the Code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. There is a Māori health plan to support practice and individual values are considered during care planning. A complaints process is implemented and there is a complaints register.

## Organisational management

Dominion Home is implementing a quality and risk management system that supports the provision of clinical care. There is a current business plan in place. An experienced facility manager/registered nurse is responsible for the daily operations of the home. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

Family/whānau and residents, as appropriate, receive adequate information on entry to the dementia care service. The service has a well-developed assessment process and residents needs are assessed prior to entry. The registered nurses complete assessments, care plans and evaluations. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short-term care plans are in use for changes in health status. The service facilitates access to other medical and non-medical services.

The diversional therapist provides an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

There are medication management policies and procedures in place for safe medicine management practice. The service uses an electronic medication system. All staff responsible for medication administration have attended annual medication education.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Nutritious snacks are available 24 hours. Relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

There is a current building warrant of fitness. The facility is maintained with contractors used when required. There is a refurbishment programme in place. There is a safe and secure external area for residents to access. The external and internal environment is arranged with space for walking and indoor/outdoor activities. Corridors are wide enough in all areas to allow residents to pass each other safely and there are safety rails appropriately located.

Staff confirm that they have access to appropriate equipment. That equipment is checked before use and staff are competent to use the equipment. The facility provides evidence of safe storage of equipment with equipment calibrated annually.

The chemical trolley is stored in a secure area when not in use.

## Restraint minimisation and safe practice

The service has policies and procedures to appropriately guide staff on the use of restraints and enablers. There were no residents using enablers or restraints. Staff receive training in restraint and managing challenging behaviour as part of the annual training plan.

## Infection prevention and control

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

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 37 | 0 | 4 | 4 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 5 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| --- | --- | --- |
| **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 | A code of rights policy is in place. Interviews with care staff (two healthcare assistants, one facility manager, one registered nurse (RN) and one diversional therapist) confirmed their understanding of the rights of their residents and were able to describe how they incorporated rights in the care of the residents. Residents’ rights are discussed at staff meetings. Three family members interviewed spoke very highly of the staff’s respect of the residents’ rights. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relatives’ lives.  Five of five resident files sampled have a signed admission agreement and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The information pack provided to family members and residents at the time of entry to the service provides advocacy information. Advocate support is available if requested. Interviews with family confirmed their awareness of advocacy processes and how to access an advocate.  Discussions with family identified that the service provides opportunities for them and the residents 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 | Community groups including church and support groups are involved with the facility. Residents are encouraged to maintain family and friends networks. On interview all staff stated that residents are encouraged and supported to build and maintain relationships with family, friends and in the community. Entertainers regularly visit the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The facility manager/RN leads the investigation of any concern/complaint. Staff interviewed and the facility manager/RN confirmed concerns/complaints are discussed at the monthly quality/staff meeting.  The complaints procedure is provided to residents within the information pack at entry. Complaints forms are available for use. There have been no complaints lodged since the last audit. Systems are in place to ensure appropriate action is taken within the required timeframes, including family meetings and ongoing communication. Families interviewed are satisfied with the cares and services the residents receive and are aware of the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code of Health and Disability Consumers’ Rights (the Code) information is displayed in multiple locations. On entry to the service, family receive an information pack that includes the Code information and a service agreement that they can discuss with the facility manager or registered nurse. On interview all staff stated that they take time to explain the rights to residents and their family members. Family members confirmed that they had received information about residents’ rights on entry to the service. The prospective owner was familiar with the code of rights.  The service is able to provide information in different languages and/or in large print if requested. |
| 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. | PA Moderate | The residents’ personal belongings are used to decorate their rooms. Rooms were single occupancy at the time of the audit with the exception of one double room used by two residents who have shared a room for over five years. A trial period of moving these two residents to single rooms proved unsuccessful.  The healthcare assistants interviewed report that they respect the residents’ privacy and do not hold personal discussions in public areas, although during the audit one healthcare assistant was observed showering a resident with the shower door left open. Care staff report that they facilitate the residents' independence by encouraging them to be as active as possible. All of the families interviewed report that their family member’s privacy is respected.  Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect.  Multi-denominational church services are conducted in the facility. The service actively encourages residents to have choice and this includes voluntary involvement in daily activities. Interviews with all family members confirmed that resident’s choices are considered. |
| 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 established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan and recognition of Māori values and beliefs policy.  There were no residents who identified as Māori. Care staff were able to identify cultural safety issues for Māori and how they would manage these on an individual basis. The service is able to access Māori advisors with links to the Auckland DHB Maori advisory and advocacy service. |
| 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 | Information gathered during the initial assessment, including the residents’ cultural beliefs and values, is used to develop a care plan, which relies heavily on family input. The cultural diversity of residents and staff include Chinese, Indian and Samoan.  A cultural day is celebrated once a year amongst staff and residents where staff bring in food to celebrate their cultures. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies are in place to support zero tolerance against any discrimination occurring. The abuse and neglect policy covers harassment and exploitation. Family members interviewed reported that the staff respected residents. Elderly abuse prevention training, provided by Aged Concern, occurs two-yearly and includes professionalism and standards of conduct. Job descriptions define roles, responsibilities and professional boundaries. Information provided to staff at their induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice is promoted and encourage. The facility manager reports that significant improvements have been implemented which are evidenced through a culture of staff teamwork, and staff taking pride in the facility. Three registered nurses (RNs) are employed by the service, which includes a (full-time) facility manager. The prospective owner is also an RN. Three RNs have completed their InterRAI training. An RN is either on site or on call 24 hours a day, seven days a week. The general practitioner (GP) reviews residents every three months at a minimum (exceptions link #1.3.12.1). Policies and procedures are in place to guide staff and are reviewed regularly. The education and training programme aligns with policy (link #1.2.7.5).  The service receives support from the Auckland District Health Board. Podiatry services are provided monthly. Physiotherapy and dietitian services are available as needed. There is a regular in-service education and training programme for staff. A van is on-site for regular community outings. Residents are supported to safely maintain their independence.  All family interviewed expressed their satisfaction with the care delivered. The GP interviewed is also satisfied with the level of care being provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. The facility manager/RN and staff RN confirmed corrective actions have been implemented since the surveillance audit to ensure family are kept informed regarding incidents/accidents and changes in health status. This was evidenced in all seven accident/incident forms selected for review and on the family communication sheet, held in each resident’s file. Families interviewed confirmed that they are kept informed.  Monthly newsletters are sent to families to enhance communication. The facility manager reports that she has an open door to families and visitors.  Interpreter services are available as required. Families of non-English speaking residents and staff are on duty who are able to communicate effectively with the residents.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Dominion Home provides dementia level of care for up to 29 residents. On the day of audit there were 19 permanent residents including two residents under the age of 65 years on a younger person contract.  Four investors have privately owned Dominion Home for the last two and a half years. The company has one other facility. The facility manager/registered nurse (RN) was appointed in December 2014. She has had 15 years previous experience as a nurse manager within aged care and has completed a certificate in supervisory management. The facility managers/RNs of both company homes represent clinical governance at the investor meetings. The management team are supported by two part-time RNs.  The 2014 quality policy and plan was reviewed and evaluated by the investors and management team (meeting minutes sighted). A business plan and continuous quality improvement plan has been developed for 2015 to 2016. The business plan includes the service mission and philosophy of care. Environmental renovations have been included in the business plan. Painting of the interior corridors and lounge has been completed and five bedrooms have been refurbished including furnishings. Quality improvements for 2015 include new uniforms, review of all job descriptions, task lists, and the introduction of the Med-map medication system in June 2015.  The facility manager/RN has attended at least eight hours of education relating to managing a rest home including aged care provider meetings, infection control, InterRAI training (April 2015) and attendance at the gerontology conference in August 2015. The prospective owner/director/RN has completed InterRAI training.  Interview with one of the new owners advises the tentative sale date of the business is late October 2015. There will be a four-week transition period. There will be two owner/directors (tenants). One owner/director has a current retail business and the other owner/director is a New Zealand registered nurse who graduated in 2013. During her nursing studies she had placements in rest homes, assessment and rehabilitation ward within the district health board and within a mental health clinic. Prior to immigration (13 years ago), the new owner/director was a qualified teacher. Over the last month, the owner/director/RN has been on-site as the RN in the weekends and meeting with families. She has been receiving mentoring from the current business owner and facility manager.  The new owners/directors have a business plan covering objectives for the first year and includes the service mission and organisational structure. Environmental improvements include a scheduled maintenance plan a) including exterior building and grounds b) improving the internal décor for communal areas of the home c) replacement of lounge furnishings and upgrade and re-lining of three toilet and one shower area to meet infection control requirements. The board of directors aim to meet with all staff at least three times a year to discuss staffing and other facility needs. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence of the facility manager, the part-time RN and current business owner covers the facility manager’s role (and vice versa). Interview with the new owner/director/RN confirms she will cover in the absence of the facility manager (and vice versa).  A review of the documentation, policies and procedures and from discussion with staff, identified that the service operational management strategies includes culturally appropriate care to minimise 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. | PA Low | Dominion Home has implemented a quality and risk management system, which is reviewed annually. Areas for improvement are identified and are included in the quality improvement plan, including the review of all policies and procedures to meet current best practice. Not all policies in place reflect current best practice.  There are monthly quality risk management meetings held for all staff. Meeting minutes for August 2015 evidence discussion around all quality data including accidents/incidents, infection control, medications, concerns/complaints, audit outcomes, hazard management and document control.  Monthly data is collected for infection control, accidents/incidents, concerns/complaints and audit outcomes. The service participates in the national quality performance system (QPS).  An ongoing internal audit programme covers environmental and clinical areas. Internal audits are delegated to the relevant person. The business manager coordinates the internal audit programme. Corrective actions are generated and completed for any audit concerns less than 100%.  Annual resident food satisfaction surveys were completed in December 2014. The relative survey on services provided was completed December 2014. Results were collated through an external QPS company and discussed as sighted in meeting minutes. The overall result was 83.43%.  There is an implemented health and safety and risk management system in place including policies to guide practice. Health and safety objectives are reviewed annually. There is a current hazard register in place. Health and safety and hazards are discussed at staff meetings and documented in the meeting minutes. Staff interviewed were aware of the hazard identification process.  Falls prevention strategies were in place, that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Seven accident/incident forms (five for August and two for September 2015) were sampled. There has been RN notification and clinical assessment completed within a timely manner. All recorded accidents/incidents were documented in the resident progress notes.  The service collects incident and accident data and reports aggregated figures monthly to the quality risk management staff meeting. Staff confirmed incident and accident data is discussed at the staff meeting.  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.  Discussion with the facility manager/RN identified an awareness of reporting requirements to relevant personnel. |
| 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 resources policies to support recruitment practices. Five staff files sampled contained all relevant employment documentation. Performance appraisals were current for staff employed over one year. Current practising certificates were sighted for the facility manager/RN and one part-time RN. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.  An annual training programme covering all the relevant requirements is implemented and attendance records are maintained. There is external training available to the manager and RN. The home employs 11 caregivers for the dementia care facility. Three caregivers have completed the dementia unit standards and qualified. Six caregivers have completed the unit standards; however, these are still in the process of being reviewed by an external agency for verification. Two caregivers are new. The service has aged care education available on-site. There is a roving assessor available to support students through the education programme.  The facility manager/RN has registered to become a workplace assessor.Clinical staff complete competencies relevant to their role including medication competencies. At least one staff member on duty has a current first aid certificate. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager/RN is on site during the day shift Monday to Friday. A part-time RN is employed for day shift on Fridays and another part-time RN who is on overseas leave works the weekends. The new owner/director/RN is currently working the weekends. RNs share the on-call after hours.  There is a dedicated cleaner seven days a week in the mornings.  The new owner/director/RN confirmed there will be no changes to the current care and support staff. The facility manager/RN and one part-time RN (Fridays) will remain on staff. The new owner/director/RN will work the weekends replacing the current weekend RN. |
| 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Entries are legible, dated and signed by the relevant caregiver or registered nurse, including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Relatives receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the district health board (DHB). The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy, as observed during the medication round on the day of audit. The service uses an electronic medication charting and administration system. Registered nurses and healthcare assistants administer medicines. Medication competencies are completed by staff. All staff have received medication management training. The RN on duty reconciles medications on delivery and documents this. Medical practitioners write medication charts correctly. There was evidence that three monthly medication reviews by the GP were not evident in all of the sample of files reviewed. The registered nurse advised there were no residents self-medicating on the day of audit. There were no expired medications. Photo identification and allergies were identified on the medication records. |
| 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. | PA Low | There is a fully functional kitchen and all food cooked on site. The kitchen staff have completed food safety training. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. Any special dietary requirements, food preferences or dietary changes are communicated to the kitchen. Alternative foods are provided for dislikes. A registered dietitian has reviewed the four-weekly menu (April 2015). A shortfall in temperature monitoring has been identified. A cleaning schedule is maintained. Additional nutritious snacks are available over 24 hours. Family members interviewed were happy with the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to resident, should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information gathered on admission from discharge summaries, referral letters, medical notes, and from discussion with the resident/family is used to develop the initial assessment care plan and the initial resident long-term care plan. Risk assessment tools are available for use on admission and reviewed six monthly or as the resident’s health status changes. Nine residents have been assessed using InterRAI and the remaining residents will have an InterRAI assessment as their review falls due. There have been no new admissions requiring long-term care since 1st July 2015. InterRAI initial assessments and assessment summaries were evident in printed format. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed described the support required to meet the residents’ goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents (as appropriate) and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status (link 1.3.8.2). Staff interviewed reported they found the plans easy to follow.  Care plans sampled document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised, demonstrate service integration and input from allied health. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) and healthcare assistants follow the care plan and report progress against the care plan daily. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the physiotherapist). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Two wounds reviewed did not have an assessment, management plan and had not been evaluated. There were no pressure injuries. The RNs have access to specialist nursing wound care management advice through the district nursing service.  Interviews with the registered nurse and healthcare assistants demonstrated an understanding of the individualised needs of residents. |
| 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 | A qualified diversional therapist (DT) is employed to deliver the activities programme for the residents. The programme is run over seven days and the care staff were observed assisting the DT with activities. The care staff continue with activities outside of the DT’s working hours. On the day of audit, residents were observed being actively involved with a variety of activities. The programme is developed weekly and is displayed in the facility. Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family etc.  The programme observed was appropriate for older people with cognition and memory impairments. Activities are age appropriate and are planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. There are also visits from community groups, church services and entertainment. The DT stated on interview that outings are planned for the warmer weather. All long-term resident files sampled have a recent activities plan, which covers individual and group activities over 24 hours. The activity plan and care plan is evaluated at the same time every six months. Families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The registered nurses evaluate all initial care plans within three weeks of admission. Four of five long-term care plans reviewed were evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly medical review by the GP. An RN signs care plan reviews. Not all short-term care plans in place have been evaluated when resolved or added to the long-term care plan if the problem was ongoing. In four of five long-term care plans where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 | Discussions with the registered nurse (RN) identified that the service has access to external and specialist providers. The service facilitates access to other medical and non-medical services. The RN could describe this. Referral documentation was maintained on resident files sampled. |
| 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. | PA Moderate | Documented processes for the management of waste and hazardous substances are in place.  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 with chemical training provided.  A visual inspection of the facility evidenced two decanted and unlabelled disinfectant sprays, which were located in showers. All other hazardous substances were correctly labelled and stored in a secure manner.  The provision and availability of protective equipment including goggles, gloves, aprons, and masks are provided and used by staff. The cleaning trolley is stored in a locked area. The cleaner interviewed confirmed his knowledge of keeping the cleaning trolley secure while cleaning. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Planned and reactive maintenance systems are in place and are reviewed. Hot water temperatures are monitored monthly and are within an acceptable range.  A current building warrant of fitness is in place (expiry 29 September 2016).  A visual inspection of the facility provides evidence of safe storage of equipment. Corridors are wide enough in all areas to allow residents to pass each other safely; safety rails are secure and appropriately located. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.  Staff interviewed confirm that they have access to appropriate equipment; equipment is checked before use and they are competent to use the equipment.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities. |
| 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 | Toilet, shower and bathing facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned, although three toilets and one shower wall are chipped and in need of repair (link 1.2.1).  The toilets have appropriate access for residents, based on their needs and abilities. Communal toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote the residents 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 | Adequate personal space is provided in all bedrooms to allow residents and staff to move around the room safely. This was also confirmed during interviews with staff and family. |
| 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 | There is adequate access to lounge, dining and other communal areas. Residents were observed moving freely within these areas. A locked half gate in the kitchen deters residents from accessing the kitchen and two locked gates prevent residents from wandering outside the property. Family interviewed confirm there are alternate areas available to them if communal activities are being run and the resident does not wish 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 policies and procedures are in place. Product user charts and chemical safety data sheets for all chemicals used in the facility were sighted in multiple locations. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. Interviews with the cleaning and laundry staff confirmed their understanding of safe and effective procedures. Family interviewed reported their satisfaction with the cleaning and laundry services. |
| 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. The service has an approved fire evacuation scheme. There is secure access to the facility by keypad code only known to staff who operate the gate and a front door system that allows entry to authorised persons only. The operating system was observed several times throughout the audit day. The kitchen area was found to be safe and secure.  Emergency equipment is accessible, stored correctly, and stocked to a level appropriate to the service setting. There is a gas barbeque should the mains gas supply fail. An appropriate call bell system can be easily used by the resident or staff to summon assistance if required. Call bells are accessible/within easy reach, and are available in resident areas. There is at least one staff member with a current first aid certificate on duty at all times. |
| 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 | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are no residents who smoke. The facility manager reports that if a resident is admitted who smokes, an outdoor smoking area will be made available. |
| 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 infection control programme and its content and detail, is appropriate for the size and degree of risk associated with the service. The scope of the infection control programme is available and was last reviewed March 2015. There are defined responsibilities for the infection control coordinator (who is the facility manager/registered nurse), included in the infection control coordinator job description. The infection control coordinator provides a monthly report to the quality risk management/staff meeting.  There are adequate hand sanitisers placed appropriately within the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. |
| 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 coordinator (registered nurse) takes infection control matters to the monthly meetings. The infection control coordinator has attended external training. The facility also has access to an infection control nurse specialist, district health board personnel, GPs and public health staff as required. |
| 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 manual has been reviewed March 2015 and outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. External expertise is accessed to assist in the development of policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator provides training both at orientation and annually. Staff complete infection control questionnaires and hand washing competencies. Resident education as appropriate, is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance, to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the combined quality risk management and staff meetings. Staff interviewed state infection control rates and quality initiatives are discussed at the staff meetings. There have been no outbreaks since January 2015. The service participates in QPS benchmarking. The internal audit programme includes environmental cleaning and infection control audits. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. The restraint coordinator is delegated to the facility manager/RN. There were no residents with enablers or restraints in use. Regular training on restraints and challenging behaviour is provided. |

# 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 1.1.3.1  The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times. | PA Moderate | All rooms are single rooms with the exception of one double room. Interviews with care staff and family confirm that the resident’s privacy is respected, although this was not observed by the auditors during a tour where a resident was being showered with the shower door left open. Personal clothing is labelled. | During a tour of the facility, a healthcare assistant was showering a resident with the shower door open. The healthcare assistant reported that this was due to the small size of the shower and the lack of available space for the healthcare assistant to work in. There are other (larger) rooms available for showering residents. | Ensure the resident’s privacy is respected at all times when personal cares are given.  30 days |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | The service is in the process of liaising with an external quality consultant, regarding the implementation of policies and procedures to meet accepted good practice and the Health and Disability Services (Safety) Act 2001 standards. New policies have been introduced at staff meetings. Staff confirmed they are made aware of new/reviewed policies at staff meetings and sign to say they have read them. Interview with the new owner/director informs there will be discussion with the external consultant to implement and maintain policies and procedures following the sale. | The clinical management policies around assessment and care planning did not reflect use of the InterRAI assessment tool and risk assessments. The food service policy and procedures viewed on the day of audit had not been reviewed since 2006. | Ensure all policies and procedures are reviewed within a timely manner to reflect best practice.  180 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 Low | Medication policies align with accepted guidelines. The service uses an electronic medication system and two weekly blister packs. Medication charts have photo identification. There is a signed agreement with the pharmacy. Five of 10 medication charts evidenced that the chart was reviewed at least three monthly by GP. | Five of 10 medication charts reviewed did not evidence three monthly documented GP medication reviews. Advised these have been completed and up to date. | Ensure GP documents medication reviews at least three monthly.  60 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Fridge and freezer temperatures are monitored and recorded monthly, as per policy. Food temperatures are checked prior to serving. | Fridge and freezer temperatures require more frequent monitoring as per best practice. There are no visual displays outside the fridges or freezers. There is no documented evidence of end cooked meat temperatures as per policy. | Ensure fridge, freezer and end cooked food temperatures are taken and recorded, as per best practice (link 1.2.3.3).  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The RN interviewed confirmed that they have sufficient dressing supplies and know how to access specialist wound advice as required. On interview, the new owner confirmed that they are planning to introduce new wound care documents, which will include a comprehensive assessment, management plan and evaluation. | Two of two wounds were reviewed. Documentation consisted for brief initial details of the wounds, with RN signing and dating at each subsequent dressing. Neither wounds had a comprehensive assessment, detailed management plan and had not been evaluated. | Ensure that all wounds have an assessment, management plan and are evaluated in a timely manner.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Four of five long-term care plans reviewed were evaluated, showing progress to the desired outcome and where progress was different than expected, changes were made to the care plan. Nine of 12 short-term care plans reviewed were resolved or added to the long-term care plan for ongoing problems. | i) One of five long-term care plans had not been evaluated where progress was different than expected and changes had not been made to the care plan; ii) Three of 12 short term care plans had not been evaluated and resolved. | Ensure that all care plans are evaluated at least six monthly and that where the progress is different than expected, changes to the care plan are initiated. Ensure that all short-term care plans are evaluated and resolved in a timely manner.  60 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Moderate | Chemicals are labelled and stored in secure locked areas, with the exception of two spray bottles that contained disinfectant, that were in showers. The cleaning trolley is not left unattended when in use. Personal protective equipment is readily available. Staff received chemical safety training appropriate to their roles. | Two spray bottles containing disinfectant were not labelled and were stored in the showers. | Ensure all hazardous substances are appropriately labelled and stored securely.  30 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 | Toilets and showers are located in areas convenient for the residents. Separate toilets are provided for staff and visitors. Walls surfaces in a selection of the toilets/showers are in disrepair and cannot be easily cleaned. | Wall surfaces in three toilets and one shower are chipped and cannot be easily cleaned. | Ensure walls in toilets and showers can be adequately cleaned to meet standards of good infection control.  180 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.