# Alpine Retirement Group Limited

## Introduction

This report records the results of a Certification Audit; Partial 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:** Alpine Retirement Group Limited

**Premises audited:** Alpine View Care Centre

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

**Dates of audit:** Start date: 16 September 2015 End date: 17 September 2015

**Proposed changes to current services (if any):** A partial provisional audit to assess the service for hospital level care was not conducted at this time at the request of the providers

**Total beds occupied across all premises included in the audit on the first day of the audit:** 49

# 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

Alpine View care centre and the Alpine View Lodge is part of the Alpine View retirement village complex. A chief executive officer (CEO) and an owner /managing director, manage the facility with clinical oversight provided by an experienced clinical director. The service is currently recruiting for the position of nurse manager. The clinical director reports to the CEO, owners, and a board of directors. The service is certified to provide rest home level care for up to 87 residents within the care centre and serviced apartments of the lodge. Residents and family spoken to advise that the staff are caring and attentive and spoke positively about the care and services provided.

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

Improvements are required around advanced directives, complaints follow-up, reporting of quality outcomes to staff, sign-off of incident forms and completing clinical follow-up post incidents, aspects of training, staff files, timeliness of InterRAI assessments, aspects of medication management, medication competencies, servicing of the hoist, infection prevention practices and infection control training for the coordinator.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

Care is provided in a way that ensures residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. 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. |  | Some standards applicable to this service partially attained and of low risk. |

The clinical director is qualified and experienced for the role and an involved management team, registered nurses and care staff support her. The service has implemented a new quality and risk management programme. Quality activities, including key performance indicators are conducted and this generates improvements in practice and service delivery. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme is in the process of being implemented with a current plan in place. Appropriate employment policies are documented and an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The service has entry to service processes and resident’s needs are assessed prior to entry. A registered nurse completes assessments, care plans and evaluations. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and 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. Care plans are evaluated six monthly or more frequently when clinically indicated. 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.

Medications are stored and administered in line with good practice.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food provided.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

Chemical safety is maintained. There is adequate equipment provided to ensure the needs of residents are met and suitable equipment to provide care is available. The building holds a current warrant of fitness. A maintenance prevention programme is implemented. Electrical equipment is checked annually. There are a number of communal lounges and dining areas. There are documented laundry services policies/procedures. There is a plentiful supply of protective equipment, gloves, and aprons. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan. The facility has civil defence kits and emergency management plans.

## 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. |

A restraint policy includes comprehensive restraint procedures. There are currently no residents requiring enablers or restraints. Staff are trained in restraint minimisation and challenging behaviours.

## Infection prevention and control

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

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. Documentation evidences that relevant infection control education is provided to all service providers. 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.

## 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 | 36 | 0 | 8 | 1 | 0 | 0 |
| **Criteria** | 0 | 82 | 0 | 10 | 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 | Alpine View has implemented the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) and has policy and procedures in place. Discussions with staff (six caregivers, three registered nurses, one enrolled nurse, one diversional therapist and the clinical director) confirm their familiarity with the Code. Interviews with ten residents, including one at rest home level in the serviced apartments and three relatives, confirm the services being provided are in line with the Code. Code of rights and advocacy training has been provided. |
| 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. | PA Low | Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs written consents. Advanced directives were not completed appropriately in all files reviewed. Care staff interviewed confirmed verbal consent is obtained when delivering care. Discussions with three family members identified that the service actively involves them in decisions that affect their relative’s lives. Signed consents were present in all seven residents’ files reviewed, as were signed admission agreements. |
| 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 are in advocacy pamphlets that are available at reception. Residents’ meetings include discussing previous meeting minutes and actions taken (if any).  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 | Interviews with residents and relatives confirm that visiting can occur at any time. Family members were seen visiting on the days 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. Staff at Alpine View support ongoing access to community. 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. | PA Low | The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. Four complaints were received for 2015. Details of the management of the complaint is recorded, however, documented follow-up of complaints has not been. Complaints are discussed at the monthly management meetings. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information is provided to residents and family members that include the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The registered nurses, clinical director and managing director provide an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Monthly resident meetings have been held and residents interviewed agreed that the service always responds to issues raised and staff respect their rights. |
| 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. Observation on the day of audit and interview with staff confirms that residents’ personal privacy and information is protected. A chaplain visits daily and contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Care plans reviewed identified specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided. |
| 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. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Residents who identify as Māori have this included in the care plan and the service maintains appropriate cultural care. Links have been made with a local kaumātua who visit as needed. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety (link #1.2.7 .5 for cultural training). |
| 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 | Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed. Family involvement is encouraged (eg, invitations to residents meetings and facility functions). Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The service has guiding documents for staff to ensure residents are free from discrimination and exploitation - staff interviews verified an understanding of the code of conduct. Regular training is being offered and attendance being recorded. Interviews with residents and family's reported no discriminatory practices. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Alpine View has an implemented quality programme that monitors contractual and standards compliance and the quality of service delivery in the facility (link 1.2.3.1).  The service has implemented a new quality programme and document management system, recently purchased from an external contractor. They have also implemented a dashboard system to monitor quality data such as Incidents, accidents and infection control. As part of overall service improvement, health and safety processes have been reviewed, and health and safety committee meetings are held. A hazard monitoring process and register is in place.  The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. There are implemented competencies for caregivers and registered nurses.  Clinical improvements include increased registered nurse supervision both in the care centre and at the lodge. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Relatives interviewed confirmed they are notified of any changes in their family member’s health status.  Eleven resident related incident forms were reviewed for August. All incident forms documented that family had been informed.  Copies of completed admission agreements are held in the resident file and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet  There are documented monthly resident meetings that document a variety of resident issues that are discussed and resolved  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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Alpine View care centre and Lodge is part of the Alpine View retirement village and is owned and governed by a board of directors, with management provided by the registered nurse clinical director. The clinical director reports to the general manager/director who visits at least weekly and has a hand-on role in the running of the facility.  The service provides care for up to 87 residents in the two facilities, the care centre and The Lodge. The care centre accepts up to 47 residents at rest home level with 46 residents on the day of audit, including two respite residents. The service is also certified to accept up to 40 rest home level residents in The Lodge serviced apartments. On the days of audit, there were three residents at rest home level.  The service has a current business plan, which includes a current quality and risk management plan. The clinical director has attended in excess of eight hours of professional development in the past 12 months, which includes clinical in-service education, and attending two monthly aged care providers peer support meetings. |
| 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, a charge nurse will cover the clinical director role. The service is in the process of employing a suitable candidate. The service has well developed policies and procedures at a service level and an organisation plan that is structured to provide appropriate safe quality care to people who use the service, including residents that require rest home level care. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Alpine View has a business plan (2015 – 2017) and a quality assurance and risk management plan and matrix. Monthly reports are documented to the board and these include; health and safety, hazard control, incidents and accidents, complaints, training and audit results. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are from an external contractor and have been personalised to Alpine View. Staff have access to manuals.  A review of meetings evidence that quality outcomes are reported to all meetings with action plans as needed, however, staff meetings have not been held as planned.  Incidents and accidents, and infection control are entered into a computer software package, which produces a dashboard of results. These are provided to the management and staff for review and discussion. There is a risk and hazard register in place, which is reviewed regularly through health and safety meetings.  Monthly audits take place according to the schedule, these are reported to management meetings as well a monthly audit report completed for management and all staff. Action plans are in place for areas of noncompliance.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.  Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. |
| 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. An RN investigates all accidents and near misses within 24 hours, after which the clinical director reviews the forms and enters them onto the database. New computer software ensures that the service undertakes an analysis of incident trends. Incidents are reported to the management meeting and to the board.  Eleven incident forms reviewed document that all have an RN review with follow up. Resident files reviewed document that incidents are reflected in care plan changes as needed.  Discussions with staff confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resource management policies. A copy of practising certificates is kept.  Seven staff files were reviewed, one enrolled nurse, two registered nurses, a cook and three caregivers. The enrolled nurse and two registered nurses all have practicing certificates. Medication competencies have not been completed for all staff who administer medications (link #1.3.12.3).  Documentation relating to evidence reference checking, completion of an orientation programme and job descriptions was not evident in all the files reviewed. The service has a comprehensive orientation programme for all new staff with relevant information for safe work practice.  There is a documented in-service education programme for 2014 and 2015, which has been partially implemented. Healthcare assistants have completed an aged care education programme. The registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an appropriate staff rationale and skill mix policy in place. Sufficient staff are rostered on to manage the care requirements of the residents. The clinical director works full time and a new charge nurse is in the process of being employed. All morning shifts have a registered nurse at The Lodge and either a RN or EN in the care centre. There is someone rostered 24/7 in The Lodge. The staff interviewed advised that extra staff can be called on for increased resident requirements and the roster. 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 within 24 hours of entry into the resident’s individual record. Other residents or members of the public cannot view files containing sensitive resident information. Entries in records are legible and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The clinical director currently screens all potential residents prior to entry and records all admission enquiries. Residents (ten) and relatives (three) interviewed, confirmed they received information prior to admission and had the opportunity to discuss the admission agreement. The admission agreement form in use aligns with the requirements of the ARC contract and exclusions from the service are included in the admission agreement. All admission agreements have been updated with the changes to the ARC 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 to describe guidelines for death, discharge, transfer, documentation and follow up. Records are kept with the residents’ files. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow up occurs to ensure that the resident is settled, or in the case of death, communication with the family is made and this is documented. |
| 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 prepacked blister medication packs. Medications are checked on arrival by a registered nurse and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are stored securely in both the care centre and the Lodge. Staff sign for the administration of medications on medication sheets held with the medicines, however not all entries were dated or the dose of medication recorded. There were expired medications in the care centre medication trolley. Controlled medication balances are checked weekly. The GPs review residents three monthly, as evidenced on the medication charts reviewed. Warfarin charting does not evidence a GP signed order in all cases.  Registered nurses and/or senior caregivers administer the medication in both areas. Annual medication competencies have been completed for caregivers. Two residents who self-medicate have been deemed to be competent and medications are managed appropriately.  The service has policies and procedures in place for ensuring all medicine related recording and documentation meets acceptable good practice standards. The medication fridges are monitored.  Allergies and resident photographs were evident in all 17 medication charts reviewed and all medication orders recorded indication for use for ‘as required’ medication (PRN). |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The kitchen in the care centre is located adjoining the dining room. The serviced apartment kitchen is located beside the restaurant in the Lodge. In the care centre, there are two cooks rostered on. Both have completed food safety training. The kitchen staff at the Lodge have completed safe food handling training. All rest home residents have a nutritional and hydration care requirement developed on admission, which is reviewed at the six monthly reviews. Any special dietary requirements and food preferences are communicated to the kitchens and individual meals are supplied. The menus have been designed and reviewed by a registered dietitian, at both the care centre and Lodge. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving.  The kitchen, kitchen equipment and kitchen staff are able to meet the needs of the residents.  Equipment is available on an as needed requirement. Residents requiring extra assistance to eat and drink are assisted by caregivers and this was observed during lunch. |
| 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 reasons for declining service entry to residents should this occur and communicates this decision to residents/family/EPOA. 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 | Comprehensive assessments were completed in files sampled. All files reviewed had appropriate assessments on admission. Needs, outcomes and goals of residents were identified through the assessment process in the files sampled. Residents and family are consulted and agree to intervention outcomes. Two registered nurses from the care centre have completed InterRAI training with current competencies. The clinical director has also completed the training. The registered nurse at the serviced apartments has yet to complete the InterRAI training. Two residents admitted after 1 July 2015 have been assessed with the InterRAI assessment tool (#1.3.3.3). All other residents have assessments completed for identified care needs. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The sample of care plans evidence that all interventions have been documented for all assessed needs and support. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and input from allied health. Short-term care plans are in use for changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation reviewed and interviews with staff, residents and relatives identified that the care being provided is consistent with the needs of residents. Monitoring charts were sighted in files sampled.  Residents' needs are assessed prior to admission. During the tour of facility it was noted that all staff treated residents with respect and dignity.  Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  Wound assessment and wound management plans are in place for 11 residents with wounds – five with skin tears (link #1.2.7.5), five with skin lesions and one with complex vascular wounds. There were no pressure injuries. The registered nurse interviewed described the referral process should they require assistance from a wound specialist. |
| 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 provides activities in the care centre and an activities coordinator in the Lodge (service apartments). Two separate monthly activity programmes are developed, one for the rest home and one for the Lodge at the Alpine View retirement village.  On the day of audit, residents were observed being actively involved with a variety of activities in the care centre and at the Lodge. The weekly plan is posted in each corridor. 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, and family. Activities are age appropriate and planned. The programmes running for residents are meaningful and reflect ordinary patterns of life. There are also visits from community groups.  Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff through residents’ meetings or following activities. There are regular outings. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by a registered nurse six monthly or when changes to care occurred. Evaluations were documented and included progress toward meeting goals. There was documented evidence of care plans being updated as required.  There is at least a three monthly review by the GP.  There are short-term care plans to focus on acute and short-term issues and these are reviewed and signed off when resolved. |
| 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 clinical director and registered nurses identified that the service has access to external and specialist providers. 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. | FA | The waste management policy and procedure outlines processes. Staff were observed wearing appropriate protective clothing. All chemicals sighted were appropriately stored in locked areas and fully labelled. There is an incident reporting system that is in use. A comprehensive emergency plan is available to staff which includes hazardous substances. |
| 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 | The care centre has a current building warrant of fitness sighted, which expires on 1 September 2016. The Lodge building warrant of fitness expires on 1 April 2016. The care centre facility is maintained in good order with regular maintenance. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person. Electrical appliances are tested and tagged by a contracted service. The sling hoist in the care centre has not been checked.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. The external areas are well maintained and residents access gardens and indoor areas with ease. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All rooms in the care centre and in the service apartments have full ensuites. There were sufficient numbers of resident communal toilets in close proximity to communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets were well signed and identifiable. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. The resident rooms are of sufficient size to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed reported that rooms have adequate room to allow cares to take place. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas are easily and safely accessible for residents. There are lounge areas and separate dining rooms, and small seating areas by the reception. The main dining room in the care centre is spacious, and located directly off the kitchen/server area. The furnishings and seating are appropriate for the resident group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. |
| 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 | Rostered cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.  All laundry is done on site by designated staff. Residents and relatives interviewed were satisfied with the laundry service. The laundry and cleaning services are able to cater to the needs of the rest home residents. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures are in place. Fire evacuation drills take place every six months. The orientation programme and education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan is in place.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and the availability of a gas cooking. A back up battery for emergency lighting is in place.  A call bell system is in place in the residents’ rooms and communal areas. Residents have access to their call bells in their rooms. Residents and family reported that staff answer call bells in a timely manner.  There is a minimum of one person rostered on each shift with a current first aid/CPR certificate.  External lighting is adequate for safety and security. Doors are locked at dusk. |
| 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 | All bedrooms and communal rooms have an opening window to the outside. Underfloor heating ensures warmth and all areas were warm and well ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| 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. | PA Low | 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 quality management system. The clinical director is the designated infection control nurse with support from the registered nurses and all staff (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all staff. During a tour of the facility it was noted that infection prevention practices are not always adhered to. |
| 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. | PA Low | The clinical director is the designated infection control (IC) nurse, however, has not completed infection control training. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff through the staff/quality meeting) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. 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 | Alpine View have implemented new policies 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. |
| 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. Formal infection control education for staff has occurred and is part of the annual education programme. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Systems in place are appropriate to the size and complexity of the facility. 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. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at quality meetings and staff meetings (link 1.2.3.1). If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical director. An outbreak in October 2015 was reported and appropriately managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers including definitions. The clinical director is the restraint coordinator and is knowledgeable regarding this role. During the audit there were no residents using a restraint or an enabler. Staff receive training around restraint minimisation and managing challenging behaviours. Care staff interviewed understand the difference between an enabler and a 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 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | There are policies and procedures available in regards to informed consent, resuscitation and advanced directives. Staff have received training around informed consent. Advanced directives including resuscitation orders, were completed appropriately in five of seven resident files reviewed. | Two of seven resident files reviewed did not identify that the advanced directive had been completed appropriately. A family member had signed one rest home resident resuscitation order and one respite resident did not have an advanced directive completed. | Ensure that all residents have advanced directives including resuscitation orders completed appropriately.  90 days |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | There is an appropriate complaint policy in place. Four complaints reviewed have been investigated and documented as closed out. The complaints management process has been recorded. None of the complaints reviewed have documented replies to the complainants. | Of the four complaints reviewed, none document formal written replies to the complainant. | Ensure that all complaints have documented follow up to the complainant.  60 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | Alpine View has meeting and quality reporting processes documented. The meeting planner includes weekly head of department meetings, six weekly management meetings, monthly staff meetings and monthly health and safety meetings. Staff meetings reviewed have not all been held as scheduled. Infection control and restraint (if there is any) are included as part of the management meetings. | The service has not held monthly staff meetings between May and August 2015. | Ensure meetings are held as planned to provide evidence that quality activities are communicated to staff.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Four of the seven staff files reviewed documented reference checking prior to employment. There are job descriptions in place for all roles within the service and there is a documented orientation programme in place. Staff interviewed stated that they had all had an orientation upon employment. | Of the seven staff files reviewed, three had no references documented, orientation was not documented in four staff files and six staff files did not have a job description on individual staff files. | Ensure that employment and orientation documentation is in place for all employees.  60 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a documented education schedule in place for 2014 and 2015. Education and training is recorded on individual files. Not all education has been provided as per the annual training plan. | A review of the education provided over 2014 and 2015 evidences that culture/Treaty of Waitangi training, medication and wound/skin care training has not been provided. | Ensure that all training is provided as per schedule.  60 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medication policies align with accepted guidelines. Medications are stored securely. The service uses weekly blister packed medications for regular medications. Allergies and a current resident photograph was evident on the 17 medication charts reviewed – 14 in the care centre and three in the service apartment Lodge. There is a signed agreement with the pharmacy. Staff have signed accurately for the administration of medications on 10 of 17 medication signing sheets reviewed. Two medication trolleys in the care centre were observed with expired medications. The charting of warfarin was noted to be correct for one of four residents in the care centre who are on warfarin. The medication folder includes a list of specimen signatures. | (i) Four medications on a medication trolley in the care centre were noted to be expired; (ii) Seven (of 17) medication signing sheet entries in the care centre were not dated on the day of administration; (iii) three of four residents on warfarin did not have a signed warfarin medication order. The order was faxed through to the service from the GP practice based on the INR result, but a GP signature and registration number was not included in the order; (iv) the dose of medication given for ‘as required’ medications was not recorded on all occasions for two residents on warfarin and two residents on controlled drugs (care centre); (v) transcribing of medication orders was noted for one resident in the service apartments. | i) Ensure that all medications in use are within use by dates; (ii) ensure that all medication administration entries are dated; (iii) ensure that all warfarin administered is based on a signed medication order; (iv) ensure that the dose of all ‘as required’ medications administered is recorded on the signing sheets; (v) cease the practice of transcribing medication orders.  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Registered nurses, enrolled nurses and senior caregivers are responsible for administering medications in the care centre and in the service apartments. Medication training is required (link #1.2.7.5). Senior caregivers have completed annual competencies. The enrolled nurse has completed competencies, however this has expired. Registered nurses have not completed annual competencies. | Medication competencies for three registered nurses have not been completed and one enrolled nurse medication competency has expired. | Ensure that all staff that are responsible for administering medications have annual competencies conducted.  60 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 | The service has a suite of risk assessments, which were evident in the sample of seven files reviewed. The assessments included pain, falls risk, pressure risk, continence and nutritional. The initial assessment and initial care plan were completed within 24 hours of admission. The risk assessments have been utilised on which to base the long-term care plan. Two residents who were admitted since 1 July 2015 have had the InterRAI assessment completed outside the required time frames. | One care centre resident had the InterRAI assessment completed eight weeks after admission and one serviced apartment rest home resident had the InterRAI assessment completed four weeks after admission. | Ensure that all new residents admitted after 1 July 2015 has the InterRAI assessment completed no later than 21 days after admission (as per ARC contract requirements).  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | An authorised electrician has tested and tagged electrical equipment. The service has new sit on scales and a sling hoist. Medical equipment has been calibrated, with the exception of the hoist. Advised by staff that the hoist is used infrequently. Safe manual handling training has been provided. | The sling hoist located in the care centre has not been serviced or checked by an authorised technician. | Provide evidence that the sling hoist available in the care centre, has been checked and serviced by an authorised technician.  90 days |
| Criterion 3.1.9  Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious. | PA Low | The infection control programme includes education and training for staff at orientation and through the annual training programme. Staff have personal protective equipment available. Linen trollies in the hallways of the care centre were noted to be uncovered. | Infection prevention and control is not always practised. Linen trollies were noted to be left uncovered in each of the four hallways in the care centre, and washing baskets were observed to be placed on top of clean linen. | Ensure that best practice infection prevention procedures are adhered to.  30 days |
| Criterion 3.2.1  The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard. | PA Low | The infection control team have recently implemented a new infection control programme and this is now integrated in to practice and reporting. The IC nurse has not completed infection control training. | The clinical director has not had infection control training in order to lead the team. | Ensure the infection control nurse accesses infection control training.  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.