Harbour View Rest Home (2005) Limited - Harbour View Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Harbour View Rest Home (2005) Limited
Premises audited:	Harbour View Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 October 2015 End date: 6 October 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 45

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

Indicator	Description	Definition
	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

Harbour View rest home is owned and operated by a husband and wife team. One owner is the designated manager. An assistant manager, registered nurses and care staff support the manager. The service is certified to provide rest home and dementia care for up to 45 residents with full occupancy on the days of audit. Harbour View has a quality and risk management system in place. Residents and families interviewed were complimentary of the care and support provided.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Improvements are required in relation to communication with families, consent for sharing rooms, clinical review of residents following incidents and accidents, aspects of the education programme, staff signing of documents, timeframes for assessment and care plan completion, aspects of care planning including assessments, plans, interventions and evaluations, aspects of medication management and servicing and calibration of equipment.

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.

Staff at Harbour View strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Staff interviewed were familiar with processes to ensure informed consent. 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 medium or high risk and/or unattained and of low risk.

Harbour View is certified to provide rest home and dementia specific level of care. There were 45 residents on the day of audit. The owner/manager has the responsibility of running the facility and she is supported by another owner, an assistant manager,

three part time registered nurses and care staff. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Residents meetings have been held and residents and families have been surveyed. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Staff files are maintained and annual appraisals have been conducted. 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.

There is evidence that service provision is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their satisfaction with services provided and access to a typical range of life experiences and choices.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Staff responsible for medicine management have current medication competencies. There were no residents self-administering medicines on days of the audit.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

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.

A current building warrant of fitness is in place. There is a preventative and reactive maintenance programme in place. The environment is appropriate to the needs of the residents, including a secure area for residents with dementia. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

All laundry is washed on site. Cleaning and laundry systems are monitored to evaluate the effectiveness of these services. Protective equipment and clothing is provided and is used by staff. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. External garden areas are available with suitable pathways, seating and shade provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Harbour View has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint or enablers.

Infection prevention and control

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

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 as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	33	0	6	5	1	0
Criteria	0	80	0	6	6	1	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.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (three caregivers, one activities coordinator, two registered nurses, one assistant manager and one manager) confirm their familiarity with the Code. Interviews with eight rest home residents and five relatives (three dementia and two rest home) confirm the services being provided are in line with the Code of rights. Code of rights and advocacy training has been provided for staff.
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	The informed consent policy guides service providers in relation to informed consent. Residents' files reviewed evidenced formal, documented consent relating to general consent and evidence of advance directives signed by the resident. Residents confirmed they are supported to make informed choices, and their consent is obtained and respected. There is a double room in the dementia unit that is shared by two residents; however, the required consent for sharing the room has not been obtained.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. 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. Harbour View staff 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.	FA	A complaints policy and procedure is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. There have been no complaints lodged for 2015 and two for 2014, which have been managed and resolved. A review of the complaints log/register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents and family within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identify they are well informed about the code of rights. The managers and registered nurses provide an open-door policy for concerns or complaints. Resident meetings have been held providing the opportunity to raise concerns in a group setting. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Seven care plans reviewed identify 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 and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. No residents at Harbour View identify as Māori. There is information and websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training is required (link #1.2.7.5).
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. Family involvement is encouraged. Care plans reviewed include the residents' social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules and a Harbour View code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with staff and management. Interviews with staff confirm their understanding of professional boundaries.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The recent resident satisfaction survey reflects high levels of satisfaction with the services received. Policies and procedures have been updated by the external policy provider and are available to staff. Staff meetings and residents meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by manager and registered nurses. There are implemented competencies for caregivers. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	Policies are in place relating to open disclosure. Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. A sample of incident reports reviewed for July and August 2015, and associated resident files, did not evidence recording of family notification. Care plans do not always document resident or family involvement. Relatives interviewed advised that they are notified of any changes in their family member's health status. The manager and registered nurses can identify the processes in place to support family being kept informed. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Harbour View rest home is owned and operated by a husband and wife team. One owner is the manager. The service is certified to provide rest home and dementia specific care to up to 45 residents (27 rest home and 18 dementia), with full occupancy on the days of audit. Harbour View has clearly defined goals and objectives for business management, quality and risk management and resident service delivery. The mission statement, and vision and values of the services include promoting resident's independence, respecting cultural values and providing a caring homelike environment. Annual review of the quality and risk management programme is conducted. The manager has been in the role for 14 years, is an experienced health administrator, and has attended in excess of eight hour's professional development in the past 12 months. An assistant manager, registered nurses and care staff support the manager. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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	In the absence of the manager, the assistant manager would assume the role with support from the registered nurses.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The business plan, quality assurance, and risk management planning procedures describe Harbour View's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored by the management team and discussed at management and staff meetings. Monthly reviews have been completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with the registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings are held. Restraint and enabler use is reported within the management meetings. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Results from the March 2015 survey were overall very positive and results have been discussed with staff. Feedback to residents and families has been provided via the facility newsletter. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule, which is completed by the assistant manager. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has policies/procedures to support service delivery including the use of the InterRAI assessment tool. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. New policies reviewed and introduced have been forwarded to staff and discussed at staff meetings. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.

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.	PA Moderate	There is an accidents and incidents reporting policy. Advised that the assistant manager conduct's collation and analysis of incident trends. There is a discussion of incidents/accidents at staff meetings, including actions to minimise recurrence. A review of a sample of incident and accident forms for July and August 2015 was conducted. Corresponding resident files were also reviewed. Advised that a registered nurse conducts clinical follow up of residents, however, documentation reviewed did not support this. Not all forms reviewed were completed. Discussions with the manager 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 in place, which includes recruitment and staff selection process that requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurse and general practitioners is kept. Six staff files were reviewed evidence that reference checks are completed before employment is offered. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Caregivers have completed an aged care education programme. The manager, assistant manager and registered nurses are able to attend external training. Annual staff appraisals were evident in files reviewed for staff who had been employed for longer than one year. The education plan for 2014 and 2015 was reviewed. Not all educational requirements have been provided. Eight caregivers work in the dementia unit – six have completed the required dementia unit standards and two are in the process of completing. These two staff members have been employed in the last 12 months. The activities coordinator has completed the required dementia unit standards. Two registered nurses have completed the InterRAI training and one registered nurse has not yet started the training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and dementia residents. At least one staff member is rostered on in each area at any one time with one staff member on-call. The manager and registered nurses share on-call after hours and weekends. Advised that extra staff members can be called on for increased resident requirements. Interviews with three caregivers, residents and family members identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer	PA Low	The resident files are appropriate to the service type. Residents entering the service have all relevant

Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public are unable to view sensitive resident Information. Progress notes are entered onto an electronic record. Each staff member has a log-in and password and the staff member making the entry is automatically recorded against the progress notes entry. Registered nurse entries are infrequent (link #1.2.4.3). Paper based notes did not fully evidence full sign-off and dating of all documents. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Entry processes are recorded and implemented. The service's philosophy is communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information for rest home residents (refer to criterion 1.1.9.1). The residents' admission agreements evidence resident and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home and dementia level of care (refer to criterion 1.3.4.2).
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and coordinated manner. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident.
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 High	The medication area including controlled drug storage evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The medication fridge temperatures are conducted and recorded. All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained. Staff specimen signatures are recorded; however, GP signatures log was unavailable. Staff stated there are 14 GPs providing medical services at the facility. Medicine charts are typed by the manager and evidence residents' photo identification, legibility and three

		monthly medicine reviews, however the 'as required' medicines and discontinued medicines require correct prescribing to be implemented. There were no residents self-administering medicines at the facility.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a seasonal menu reviewed by a dietitian. The residents' dietary requirements are inconsistently documented. There were 20 copies of the residents' dietary profiles in the kitchen (refer to criterion 1.3.4.2). Interviews with residents confirmed satisfaction with meals and preferences provided for. Food preparation and the provision of meals aligns with safe food standards and practices. The residents' files demonstrate monthly monitoring of individual resident's weight (refer to criterion 1.3.6.1). In interviews, residents stated they were satisfied with the food service. The food temperatures are recorded, as are the fridge and freezer temperatures. Kitchen staff have completed food safety training.
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	A process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	The facility has processes in place to seek information from a range of sources, for example, family, GP, specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The residents' files evidenced residents' discharge/transfer information from the district health board (DHB), where required. Assessments are conducted in a safe and appropriate setting including visits from the doctor, however review of residents' files evidenced that not all required assessments were completed. The registered nurses (RN) are trained in InterRAI, however InterRAI assessments have not been completed for residents' requiring them.
Standard 1.3.5: Planning Consumers' service delivery	PA Moderate	There are two types of residents' care plans used at the facility. One care plan is a generic, typed plan, that uses same goals for each resident and the interventions are recorded briefly and the relevant

plans are consumer focused, integrated, and promote continuity of service delivery.		intervention is circled to indicate it applies to that resident. The second care plan has been introduced recently and is a hand written plan with more detailed interventions. In resident files sampled the care plan interventions on both care plans do not consistently reflect the risk assessments and the level of care required. In interviews, staff reported they receive adequate information for continuity of residents' care. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	The GP documentation and records are current. In interviews, residents and family confirmed they and their relatives' current care and treatments meet their needs. Nursing progress notes and observation charts are maintained (refer to criterion 1.2.4.3). In interviews, staff confirmed they were familiar with the current interventions of the resident they were allocated. The residents' files reviewed do not consistently record the interventions contributing to meeting the residents' needs. In the residents' files reviewed, there is evidence the continence assessments record the products appropriate for the resident (refer to 1.3.3.3). There is evidence in the three wound records sighted, that wound care treatments do not follow good practice guidelines and timeframes of dressing and wound monitoring are not always adhered to.
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	In interview, the activities coordinator (AC) confirmed they plan, implement and evaluate the activities programme (refer to criterion 1.2.7.5). There is one activities programme for the rest home and the dementia unit. Along with the AC, the care staff in the dementia unit implement individual resident's activities, stated by the manager, the AC and the caregivers in the dementia unit. This was observed to be occurring during the audit. Regular exercises and outings are provided for those residents able to partake. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. The residents' activities attendance records are maintained. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme. The activities 24 hour care plans are not consistently completed (refer to criterion1.3.5.2).
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a	PA Low	Timeframes in relation to care planning evaluations are documented; however, evaluations do not consistently record the achievement towards meeting residents' goals. The residents' progress records are computer based (refer to criterion1.2.4.3). When resident's progress

comprehensive and timely manner.		is different from expected, the RN contacts the GP, as required. Short-term care plans are not consistently completed for short-term problems and when completed they do not record the required interventions. There is recorded evidence of additional input from professionals and specialists, if this is required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist service provider assistance. Acute/urgent referrals are attended to immediately, sending the resident by ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place. Interview with a cleaner confirmed there is safe storage and safe use of chemicals. Sluice facilities are provided for the disposal of waste. There was evidence that chemicals are correctly labelled and securely stored. Material safety data sheets are available and accessible for staff. Protective clothing and equipment that is appropriate to the recognised risks associated with waste or hazardous substance being handled is available. Staff were using protective clothing and equipment on audit days.
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	There is a current building warrant of fitness. There is a preventative and reactive maintenance programme in place. The testing and tagging of electrical equipment is current, however the calibration of medical equipment and hoists requires completion by authorised personnel. Staff confirmed they have access to appropriate equipment. Hot water temperatures are monitored monthly and maintained at a safe temperature. Residents are protected from risks associated with being outside. This includes a secure external area for residents with dementia. Rest home residents confirmed they are able to move freely around the facility

		and that the accommodation meets their needs.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are an adequate number of accessible showers, toilets and hand basins for residents. There are a number of ensuite rooms in the rest home and the dementia unit. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Bathrooms have appropriately secured and approved handrails, along with other equipment/accessories that are required to promote resident independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are two shared rooms, one in the rest home and one in the dementia unit (link 1.1.10.4). All rooms are personalised to varying degrees. Bedrooms are sufficient in size to provide personal space for residents and allow staff and equipment to move around safely.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Adequate access is provided to lounges and dining areas. Residents were observed moving freely within these areas. Rest home residents confirmed there are other areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. The furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely.
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	FA	Care staff manages the laundry duties. A laundry person is employed in the afternoons and responsible for the overall management of the laundry. The laundry person described the management of the laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents. Staff cleaning and laundry policies and procedures are available. The effectiveness of the cleaning and laundry services is audited via the internal audit programme.

is being provided.		Residents and families confirmed they were satisfied with the cleaning and laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A New Zealand Fire Service approved fire evacuation plan is in place. Regular six monthly fire drills have been conducted. There is at least one staff member on each shift with a current first aid certificate. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff. There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in close proximity.
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	Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
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	Harbour View rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control nurse, with support from the managers and 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 new staff on orientation. The infection control programme was last reviewed in March 2015.
Standard 3.2: Implementing the infection control programme There are adequate human,	FA	A registered nurse at Harbour View is the infection control nurse. 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 the management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		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	Infection control policy and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were originally developed by an external provider and have been reviewed and updated annually by the manager and registered nurses.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. The infection control nurse has provided infection control education for staff. The IC coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are recommended not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Harbour View's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. A monthly infection summary for rest home and dementia residents is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. No outbreaks have been reported in the past six years.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. The facility was not utilising restraint on audit day and no residents have an enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on restraint and enabler use has been provided. Restraint use audit has been conducted and restraint has been discussed as part of staff and management meetings. A registered nurse manager is the designated restraint coordinator.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	PA Low	Residents and family interviews confirmed consent is obtained when required. Two residents with dementia share a room; however, no formal agreement from families is recorded.	There is no recorded evidence of an agreement with the families for the two residents with dementia who share a room.	Provide evidence of an agreement from families for the residents’ with dementia to share a room. 90 days
Criterion 1.1.9.1 Consumers have a right to full and frank information	PA Low	The service has policies and procedures in place to guide staff around communication with residents and family. Family members interviewed advised that the registered nurses inform them of any adverse events or changes in health status of the residents. On review of a sample of incident	i) Recording of communication with family following incidents and accidents is not evident in the sample of incidents forms and associated residents files reviewed; ii) Seven initial cares plans and long-term care plans reviewed do not clearly evidence resident and family involvement.	i) Ensure that communication with family is recorded; ii) Ensure that resident and

and open disclosure from service providers.		reports and following a review of a sample of resident files, it is not evident that all opportunities for communication have been utilised.		family involvement is recorded during the care planning process. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incident and accident reports reviewed for July and August included falls, medication errors, fractures, skin tears, bruising, and behaviours. The sample of 12 reports involved seven residents. The resident files reviewed included tracking of the incident, review of forms and entries in to progress notes of the event but not always review of risk assessments and care planning for the individual residents. Falls prevention and management was well documented in the care plans reviewed. Wound care plans were in place for skin tears and short-term care plans had been developed. Not all forms reviewed were completed showing the clinical care and investigation conducted by the registered nurses.	i) A review of seven residents, (with corresponding incident reports for falls no injury, falls with skin tears, a fall with fracture, and behaviours), did not evidence that a registered nurse had recorded that clinical assessments of the residents had been conducted. One dementia resident with two falls sustained in August; and one rest home resident who sustained three falls in August had not had falls risk assessments reviewed and the long-term care plan did not reflect the falls risk and falls prevention measures required. One dementia resident who sustained a head injury did not have a full set of neurological observations completed. The resident files and progress notes did not evidence the recording of RN follow up; ii) Six of 12 incident reports reviewed were incomplete. Care staff had commenced the incident report; however, the forms had not been completed. Investigation and sign off was not documented.	i) Ensure that a registered nurse conducts a timely clinical assessment of residents who experience an adverse event, and provide evidence appropriate clinical care is provided and that this is recorded on the resident's records; ii) Ensure that all adverse event documentation is completed including investigations and sign off. 30 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	Six staff files reviewed evidence that recruitment and staff selection processes have been followed. Reference checks are conducted prior to employment. Annual appraisals have been conducted for four of six staff files reviewed. Two staff have been employed for less than one year. There is an annual education and training plan, which is being completed for 2015. Staff have received training around fire evacuation, chemical safety, infection control, medication management, restraint, pain management, and first aid, code of consumer rights and abuse and neglect. Training has also been provided around conducting neurological observations and completing incident reports (link finding #1.2.4.3). Caregivers are facilitated to complete a recognised training programme. Caregivers, who have been employed for over one year, have completed dementia unit standards. Not all required training has been provided.	Education around cultural safety, wound care, challenging behaviours, sexuality and intimacy, and continence management has not been provided in the past two years.	Ensure that training is provided to meets the needs of all staff. 90 days
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Resident files reviewed as part of incident report follow-up and clinical files review evidenced that caregivers were making entries on a daily basis. Registered nurse entries are less frequent (link #1.2.4.3). Electronic entries in progress notes record the person making the entry. Not all paper-based documents were fully completed.	Rest home and dementia resident files reviewed did not evidence full sign-off and dating of all documents including risk assessments, nursing assessments and recreation assessments.	Ensure that all documents are fully completed, including dating and signature of the person making the entry or completing the document. 90 days
Criterion	PA High	All medication charts are typed. Interview with the	i) Four of twenty medication charts evidence the	i)provide

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.		manager and the pharmacy technician confirmed the manager of the facility types the residents' medication charts. The manager stated they receive resident's medication list from the resident's pharmacy on admission to the facility. The medications are then typed on to the facility's medication chart. The registered nurses conduct medication reconciliation and checks the medication chart with the pharmacy list. The GP signs the typed medication chart prior to this being administered by staff. All seven GP's who provide medical services to Harbour View, have provided signed written instructions that they are happy for the manager to type out their medication charts. Twenty medication charts were reviewed (eleven rest home and nine dementia).	'as required' medicines are typed incorrectly by the manager, however they are signed by the GPs. ii) Five of twenty medication charts evidence the discontinued medicines are dated, however not signed by the GPs. iii) Transcribing of all medication charts occurs prior to them being signed by the GP.	evidence that 'as required' medications are charted correctly; ii) ensure that discontinued medicines are signed by the GPs; iii) cease the practice of having all medication charts typed out by the manager for the GP's to sign. 7 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	PA Moderate	Interviews with residents and family confirm appropriate services are provided at the facility. Long-term care plans are completed within three weeks of resident's admission to the facility. There is evidence in the files reviewed of timeframes adhered to.	i) Initial care plans have not been completed within the required timeframe in one of four rest home files sampled. ii) GP initial assessments have not been completed within the required timeframe in three of four rest home files and two of three dementia files sampled. iii) Risk assessments have not been completed within the required timeframes in two of four rest home files and one of three dementia files sampled.	Provide evidence the required timeframes are adhered to. 60 days

the consumer.				
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Residents are admitted to the facility with appropriate referral/admission documentation. Residents' files reviewed evidenced need assessment appropriate to rest home and dementia level of care. Assessments are conducted in a safe and appropriate setting. The review of residents' files evidenced not all required assessments were completed and the InterRAI assessments have not been completed for residents' requiring them.	i) InterRAI assessments have not been completed for one resident with dementia and two rest home residents that were admitted to the facility when the InterRAI assessments should have been completed. An InterRAI assessment has not been completed for a resident with dementia, whose needs have been identified as requiring increased level of care. ii) Pain assessments for a rest home resident who was admitted with chronic pain and had an episode of acute pain, had not been completed. ii) Dietary assessments are completed as part of the RN initial assessment. A full dietary profile is not completed when the assessment identifies that the resident has no special requests. Information relating to likes and dislikes, portion size and any changes are not recorded for all residents. There was evidence of 20 completed dietary profiles in the dietary folder in the kitchen.	Provide evidence assessments are completed as required. 30 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing	PA Moderate	The care plans are completed by the RNs. The facility has introduced new care plans that are more individualised than previous care plans. The care plans sighted did not consistently record the required intervention. The residents with dementia did not consistently have strategies recorded for behaviours that challenge and the 24-hour activities care plans were not completed or up-to-date.	i) Risk assessment findings/ratings were not recorded on three of four rest home long-term care plans and two of three dementia care plans sampled. ii) Long-term care plans did not record up-to-date interventions required in two of four rest home and one of three dementia care plans reviewed. iii) 24 hour activities care plans were not recorded for two of the three residents' with dementia and the one 24 hour activities care plan that was recorded had not been evaluated and did not reflect current interventions for that resident.	Provide evidence the care plans record all the required support and intervention to achieve the desired outcomes for residents. 60 days

assessment process.			iv) Behaviours that challenge strategies were not recorded in two of the three files for residents with dementia.	
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	In interviews, residents and family confirmed their satisfaction with services provided. The residents' files reviewed do not consistently record the services/interventions contributing to meeting the residents' needs.	i) One rest home resident's weight records evidenced weight loss that was not recorded in a short-term care plan, long-term care plan, progress notes or the GP medical notes. The resident's dietary assessment was reviewed, however does not record the additional dietary supplements the resident is receiving. Kitchen staff and the RN were aware of the dietary supplements. ii) Rest home tracer methodology resident's file records the required regime for monitoring their medical condition; however, this is not conducted as required. iii) There is evidence in the three wound records sighted, that wound care treatments do not follow good practice guidelines and timeframes of dressing and wound monitoring is not always adhered to.	Provide evidence interventions are consistent with, and contribute to meeting residents' needs and outcomes. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to	PA Low	Care plan evaluations do not consistently record the degree of achievement towards meeting the resident's goals.	Care plan evaluations do not consistently record the degree of achievement towards meeting the resident's goals.	Provide evidence the evaluations of care plans document the degree of achievement towards meeting residents' needs.

the support and/or intervention, and progress towards meeting the desired outcome.				90 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	Interviews with the RNs confirmed they contact the GP when a resident's condition alters. This was also confirmed at GP interview. Short-term problems were not consistently recorded on short-term care plans. Documented short-term care plans recorded interventions that were not specific/detailed enough for the problems identified.	i) Short term care plans were not completed for short-term problems in two rest home files and one dementia file sighted. ii) The short-term care plans did not record the required interventions for short-term problems in two rest home files and one dementia file sighted.	Provide evidence the short-term care plans are completed for short-term problems and the short-term care plans record all the required interventions. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Electrical equipment checks are completed and current. Some of the medical equipment was signed as checked by a GP. There was no recorded evidence of other medical equipment being calibrated. There are two hoists at the facility and these have no current checks in place.	i) Medical equipment has not been calibrated by an authorised person. ii) Hoists have not been checked.	Provide evidence the medical equipment is calibrated and hoists have been checked. 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.

No data to display

End of the report.