

Lady Joy Home Limited - Lady Joy 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 Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Lady Joy Home Limited	
Premises audited:	Lady Joy Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 29 October 2015	End date: 29 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:	19	

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

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

Lady Joy Home provides rest home level care for up to 31 residents. The service is managed by the two owners/directors. One of the owners is the nurse manager. The residents and families were complimentary of the care provided.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the District Health Board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management and staff. The service continues to provide services of a high standard. There are no areas identified as requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. This information is

brought to the attention of residents (where able), and their families on admission to the facility. Residents and family members confirmed their rights were being met, staff were respectful of their needs and communication was appropriate.


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

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

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

One of the owners/managers is responsible for the management of complaints and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Lady Joy Home Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management systems are fully implemented. Documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the services provided including regular monthly meetings that are attended by the owners/managers.

The facility has been owned by the two directors/managers for the last 15 years. One of the owners/directors is the general manager and the other, is the nurse manager. The nurse manager is a registered nurse and is responsible for the oversight of the clinical services in the facility.

Quality and risk management systems are in place. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans are being developed, implemented, monitored and signed off as being completed to address any issue/s that required improvement.

Reporting on various clinical indicators, quality and risk issues and discussion of any trends identified are reported via the quality/staff meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management. Current annual practising certificates for health professionals who require them are retained. An in-service education programme is provided for staff monthly. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is evidence that each stage of service provision is developed with resident and/or family input, within the required timeframes and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

A sampling of residents' clinical files validated the service delivery to the residents. Assessments are conducted on admission and the initial care plan is documented that is specific to the resident's needs and goals. Long term care plan is completed within three weeks of admission and reviewed six monthly. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

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

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. There is policy on residents' self-administering medicines, however there were no residents self-administering medicines on audit day.

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.		Standards applicable to this service fully attained.
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All building and plant comply with legislation with a current building warrant of fitness displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

There is a mix of single and double bedrooms. Residents' rooms have adequate personal space provided. There are two lounges and one dining area available. External areas are available for sitting and shading is provided.

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

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

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.
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Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There was one residents using restraint and no residents requiring enablers on audit day. Staff education in restraint, de-escalation and challenging behaviour had been provided.

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.

The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The policies and procedures guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is on-going infection control education available for all staff.

Infection control is a standard agenda item at facility's meetings. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

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	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the ongoing education programme. The Health and Disability Advocate has provided education on the Code for staff in October 2015.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.</p> <p>The auditors noted care staff displaying respectful attitudes towards residents and family members.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>The informed consent policy guides service providers in relation to informed consent. Resident files evidenced formal, documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for the recent 'flu' vaccinations. Copies of</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these were reviewed on resident's files, where available.</p> <p>There was evidence of advance directives signed by the resident. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff training records. Staff demonstrated their understanding of the advocacy service, with contact details for the service readily available.</p> <p>The nationwide advocate details are displayed along with advocacy information brochures. Admission / pre-admission information provided evidence advocacy, complaints and Code of Rights information is included.</p> <p>Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this, although all stated they would feel comfortable about approaching the nurse manager should they have any concerns.</p>
<p>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.</p>	<p>FA</p>	<p>Residents are encouraged to maintain their community interests and networks, and to visit with their families. The service's activities programme includes regular outings in the facility's mobility van and participation in community events. Community groups, different church denominations and entertainers also visit the facility on a regular basis.</p> <p>The service welcomes visitors, and has unrestricted visiting hours. Family members advised they felt very welcome when they visit. Residents reported they are supported by staff to access health care services outside of the facility.</p> <p>Residents and family members confirmed they can have access to visitors of their choice, and confirmed they are supported to access services within the community.</p> <p>Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The general manager and nurse manager share responsibility for management of complaints. There are appropriate systems in place to manage the complaints processes. A complaints register is maintained that included two complaints for 2015 and these were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place that ensures residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The complaints process is readily accessible and/or displayed. Review of staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via the staff meetings.</p> <p>There have been no investigations by the Ministry of Health, Health and Disability Commissioner, DHB, Coroner, or Accident Compensation Corporation (ACC) since the previous audit. Documentation relating to the complaint made to the Ministry of Primary Industries (MPI) in March 2015 that was closed out in June 2015 was reviewed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code of Rights and information on the advocacy service were available and displayed at the facility. This information is provided as part of the pre-admission and information packs. The pre-admission and admission information packs were reviewed and contain, but were not limited to, information on the Code, advocacy and complaints processes. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident's admission. Residents and family interviewed confirmed explanations regarding their rights occurred on admission. They also confirmed care staff provided them with information on their rights any time they have had a query.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p> <p>Residents interviewed confirmed they had access to an advocate if needed. Residents' meetings are held monthly and the meeting minutes indicated residents are aware of their rights. The completed resident survey questionnaires indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents and family stated they</p>

		would feel comfortable raising issues with any of the staff.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents were observed being treated with respect by staff during this audit. This was confirmed during interviews of residents and family members and during review of the completed satisfaction survey questionnaires. Residents were addressed by their preferred names.</p> <p>The service's policy relating to abuse and neglect is understood by staff. Staff gave examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff have received education related to abuse and neglect. Staff employment contracts contain information relating to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met.</p> <p>There are seven double bedrooms and these are only shared by couples and with resident consent. All of these rooms provided single accommodation during this audit. Screening for visual privacy is available in the double rooms when and as required. Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff interviewed demonstrated an awareness of residents' rights and the maintenance of professional boundaries.</p> <p>Activities in the community are encouraged and the general manager and nurse manager advised some of the residents attend community events independently. Church services are held on site monthly and some residents attend church services in the community. The residents' records included documentation relating to individual cultural, religious and social needs, values and beliefs that had then been incorporated into their individual care plan. The plans also included information on the resident's abilities, and strategies to maintain/maximise their independence. These plans had been developed in conjunction with the resident and/or their family.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The organisation has a Māori health plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori health plan describes that the holistic view of Māori health is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau). The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.</p> <p>There are currently no residents who identify as Māori. Access to Māori support and advocacy services is available if required from the local District Health Board. Staff members</p>

		<p>also provide cultural advice and support for staff if required.</p> <p>A cultural assessment is completed as part of the care plan for all residents. Specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed.</p> <p>Staff were aware of the importance of whanau in the delivery of care for residents who identify as Māori. Cultural safety education is provided as part of the in-service education programme. Whanau are able to be involved in the care of their family members.</p> <p>Care staff interviewed demonstrated an understanding of cultural safety in relation to care. They also confirmed that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The individual preferences, values and beliefs of residents are included in the care plans reviewed. These plans included detailed interventions to ensure resident's individual requirements are accommodated. Residents and family members advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p> <p>During interview care staff demonstrated an understanding of cultural safety in relation to care. Staff also demonstrated processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Policies and procedures outline the safeguards to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies and procedures and staff files reviewed included copies of house rules that all staff are required to adhere to. These documents also address any conflict of interest issues including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which were reviewed on staff files.</p> <p>The general manager described the process for managing residents' 'comfort account' funds.</p> <p>A review of the accident/incident reporting system, complaints register and interview of the general manager and nurse manager indicates there have been no allegations made by residents alleging unacceptable behaviour by staff members.</p> <p>Residents and family interviewed reported that staff maintain appropriate professional</p>

		boundaries. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local District Health Board (DHB). Clinical policies, which are current and reflect best practice, are available to guide staff in care delivery. The registered nurse/nurse manager is supported to attend external education sessions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members is recorded in the progress notes. Family members expressed satisfaction with how well they were kept informed about any change to the resident's condition and their involvement in resident care planning. Resident meetings are held monthly and minutes were reviewed. The nurse manager advised that interpreter services are able to be accessed from the interpreter services if required. This information is also provided to residents/families as part of the information/admission pack. The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements were reviewed and this was clearly communicated in each 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	Lady Joy Home Limited is the governing body and is responsible for the service provided at Lady Joy Rest Home. A business plan is reviewed that includes a mission, values statement, vision, purpose, swot analysis, strengths, weaknesses, and opportunities. A quality improvement plan was also reviewed. The two owners/directors have owned, operated and managed the facility for the last 15 years. One of the owners/directors, who is a registered nurse, is responsible for management of the clinical care; the other owner/director is responsible for overall management of the facility. The annual practising certificate for the nurse manager (NM) was reviewed and is current. There was evidence on the NM's file of ongoing education. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.

		<p>Lady Joy Rest Home is currently certified to provide 31 rest home level beds and 19 of these beds were occupied during this audit.</p> <p>The service provider has funding contracts with the District Health Board (DHB) to provide aged related residential care (rest home), long term support – chronic health conditions, intermediate care services and carer relief.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the owners/managers be absent. The owners/ managers reported a senior carer/deputy manager fills in for the owners/managers if they are absent; a registered nurse fills in for the care manager. The owners/managers and senior carer/deputy manager confirmed their responsibility and authority for these roles.</p> <p>Services provided meet the specific needs of the resident group within the facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality improvement plan is used to guide the quality programme and includes goals and objectives. An internal audit programme is in place and internal audits completed in 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual was available that included relevant policies and procedures.</p> <p>Monthly staff/quality and resident meetings are held. Meeting minutes were reviewed and these are available for review by staff. Meeting minutes reviewed provided evidence of reporting / feedback on completion of internal audits and various clinical indicators. Meeting minutes for 2015 were reviewed.</p> <p>The general manager and nurse manager are responsible for ensuring the organisations quality and risk management systems are maintained.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data reviewed, including adverse event forms, internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards were identified and included in the policies and procedures manuals.</p>

		<p>Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>Health & Safety policies and procedures are available and staff are aware of and report hazards at the facility, when this is required. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the nurse manager and signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The nurse manager/registered nurse undertakes assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. The nurse manager and care staff reported the nurse manager is called if a resident has an unwitnessed fall when the nurse manager is not on duty.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting for example health and safety, human resources, infection control.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.</p> <p>The clinical manager is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided and staff attendance is high. Competency assessment questionnaires are current for medication management and</p>

		<p>restraint. The nurse manager has the required interRAI assessments training and competencies.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were in the staff files.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided Monday to Friday. The nurse manager/owner is on call after hours and lives approximately 100 metres from the rest home. The minimum amount of staff on duty is during the night and consists of one caregiver.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident related information is kept in a hard-copy file. This file is maintained securely. Archived material is also kept securely and easily retrievable.</p> <p>All components of the residents' records reviewed include the resident's unique identifier. The clinical records reviewed were well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.</p> <p>Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes clearly identify the name of the person making the entry.</p>
Standard 1.3.1: Entry To Services	FA	Entry and assessment processes are recorded and implemented. The facility information pack

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>is available for residents and their family and contains all relevant information.</p> <p>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 level of care and one for a resident requiring hospital level of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medication storage, including controlled drug storage confirmed an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained (when in use), and evidenced weekly checks and six monthly physical stock takes. There were no residents requiring controlled drugs on audit day. The medication fridge temperatures are conducted and recorded.</p> <p>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 were maintained, as were specimen signatures. Staff education in medicine management was conducted in 2015.</p> <p>Medicine charts included evidence of residents' photo identification and legibility. As required (PRN) medication was identified for individual residents and correctly prescribed. Three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. The residents' medicine charts record all medications the resident is taking (including name, dose, frequency and route to be given). There were no residents self-administering medicines at the facility.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a seasonal menu used at the facility that has been approved by a dietitian. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews. Interview with the cook confirms fridge and freezer temperatures are monitored, as are food temperatures, confirmed by review of records.</p> <p>There was sufficient staff on duty in the dining room at lunch time to ensure appropriate assistance is available to residents, if required. The dining room is clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>There is a process for informing residents, their family/whanau and their referrers if entry to the service is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents have their needs identified through a variety of information sources that include: the Needs Assessment and Service Coordination (NASC) agency; other service providers involved with the resident; the resident; family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. The nurse manager (RN) undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	FA	<p>Residents' care plans were individualised, integrated and up to date. Care plan interventions reflected the risk assessments and the level of care required. Short term care plans have been developed, when required and signed off by the nurse manager (RN) when problems had resolved. In interviews, staff reported they receive adequate information for continuity of</p>

continuity of service delivery.		residents' care. The residents have input into their care planning and review. Regular GP care is implemented and was sighted in current GP progress reports.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>Residents are assessed on admission to ascertain their recreational needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' ordinary patterns of life and include community activities and are provided Monday to Friday. Family are welcome to attend activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>Interviews with residents confirmed satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Time frames in relation to care planning evaluations are documented. Residents' care plans were up-to-date and reviewed six monthly. InterRAI evaluations are conducted. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>Residents' progress records are documented on each shift. When resident's progress was different than expected, the nurse manager contacted the GP, as required. Short term care plans were in some of the residents' files, and had been used when required. Family are notified of any changes in resident's condition. This was confirmed at family interviews.</p> <p>There is documented evidence of additional input from health professionals, specialists or multidisciplinary sources, if this was required.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services was indicated or requested, a referral is sent to seek specialist service. Referrals are followed up by the nurse manager or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident in an ambulance to DHB, if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Observations provided evidence that hazardous substances are correctly labelled, the containers appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff. For example, gloves, aprons and visors were sighted.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed that expires on the 22 June 2016. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed, the owner/general manager interviewed and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current.</p> <p>There is an external area available that is safely maintained and is appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.</p> <p>Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to</p>

		move freely around the facility and that the accommodation meets their needs.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>Some bedrooms have a wash hand basin, one has a toilet ensuite and one bedroom has a full ensuite. There are adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.</p> <p>Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is a mix of single and double bedrooms. Double bedrooms are usually only used by couples. Adequate privacy is available if bedrooms are shared. All rooms were personalised to varying degrees. Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Adequate access is provided to the lounges and dining area. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being conducted in one of these areas and they do not want to participate in them.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policy and procedures were available. There were policies and procedures for the safe storage and use of chemicals / poisons.</p> <p>All linen is washed on site and there is adequate dirty / clean flow. Care staff are responsible for laundry and they described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described cleaning processes.</p>

		<p>Observations provided evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; appropriate facilities exist for the disposal of soiled water/waste (i.e., sluice room), convenient hand washing facilities are available, and hygiene standards are maintained in storage areas).</p> <p>Residents and family interviewed stated they were satisfied with the cleaning and laundry service and this finding was confirmed during review of the satisfaction survey questionnaires.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme dated 16 October 2000 was sighted. The last trial evacuation was held on 23 October 2015.</p> <p>Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets and cell phones. The provider also has emergency generators.</p> <p>There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate</p>	<p>FA</p>	<p>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>

natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		Environmental temperatures are monitored and recorded monthly.
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control.</p> <p>The delegation of infection control matters is documented in policies, along with an infection control coordinator's (ICC) job description. The infection control coordinator is the nurse manager/ registered nurse. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The IC programme (2015- 2016) was sighted and evidences annual reviews.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: IC manual; internet; access to experts; and education. The IC is an agenda item at the facility's meetings, evidenced during review of meeting minutes and interviews with staff.
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. The IC policies and procedures are developed and reviewed regularly in consultation and input from relevant staff. IC policies and procedures identify links to other documentation in the facility.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	Infection control education is provided to all staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff advised that care staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. Infection control education is provided by the ICC. Education sessions have evidence of staff attendance/ participation and content of

		the presentations. The ICC has conducted relevant education in IC.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control coordinator /nurse manager is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at monthly meetings. The IC report analysis and evaluation from January to June 2015 was sighted.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files confirmed the residents' who were diagnosed with an infection had short term care plan.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the nurse manager, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>In interview, the ICC confirmed no outbreak occurred at the facility since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, consent, care planning, monitoring and evaluation of restraint and enabler use is recorded. There was one hospital resident using restraint on audit day. There were no enablers used at the facility on day of audit.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy</p>	FA	<p>The facility has a process for determining approval of the types of restraint used. The nurse manager (RN) is the restraint coordinator. They complete a restraint assessment and communicate with the GP and family prior to commencement of any restraint.</p> <p>The restraint was documented in the care plan of the resident. Care staff are responsible for</p>

and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		monitoring and completing restraint forms when the restraints is in use.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments include: identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. This was evident in the restraint record sighted.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The review of the resident's file using restraint was conducted and evidenced a restraint management plan was in place. Strategies were implemented prior to use of restraint to prevent the resident from incurring injury for example: the use of low beds; mattresses and sensor mats. The consent for restraint use is completed and signed by appropriate staff and family. Restraint is recorded in the resident's care plan and reviewed along with the care plan reviews. The restraint register is up to date and records all necessary information.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	There was evidence of six monthly evaluations of restraint use and monthly team meeting discussion relating to the resident's use of restraint. Each episode of restraint is evaluated. The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of restraint related matters and restraint monitoring.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Team meetings are held monthly and during these meetings the restraint issues were discussed. There is evidence of monitoring and quality review of use of restraints at the facility.

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.

No data to display

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, there 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.