# Oceania Care Company Limited - Heretaunga Home & Village

## 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Heretaunga Home & Village

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 24 November 2015 End date: 25 November 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:** 41

# Executive summary of the audit

## Introduction

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

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

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Heretaunga Home and Village (Oceania Care Company Limited) can provide care for up to 46 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored.

There are no improvements required.

## 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. |

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive.

## 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. |

Oceania has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed at head office and quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status and regional operations manager reports.

Benchmarking reports include incidents/accidents, infections, complaints and clinical indicators with trends analysed to improve service delivery.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development.

Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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. |

Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks of admission. Person centred care plans are reviewed every six months, are individualised and risk assessments are completed. Residents’ response to treatment is evaluated and documented. Relatives are notified regarding changes in a resident’s health condition.

Activities support residents’ interests and strengths. The residents and families interviewed expressed satisfaction with the activities provided by the activities coordinators and the diversional therapist.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The general practitioner completes medical reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus, reviewed by a dietitian.

## 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. |

All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks. The environment is appropriate to the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The dementia unit is secure, with outdoor areas for residents to access in both the dementia unit and for residents in the rest home.

Essential emergency and security systems are in place, with regular fire drills completed. Call bells allow residents to access help, when needed, in a timely manner.

## Restraint minimisation and safe practice

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

The restraint minimisation programme defines the use of restraints and enablers. The service has a restraint register, should they ever implement restraint or enabler use. Policies and procedures comply with the standard for restraint minimisation and safe practice. The service does not use restraint or enablers.

## Infection prevention and control

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

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files. Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing.

The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

## 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | 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 annual mandatory education programme. All staff have had training in 2015.  Interviews with staff confirm their understanding of the Code. Examples are provided on ways the Code is 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.  The auditors noted respectful attitudes towards residents on the days of the audit. Any challenging behaviours were managed for residents in the dementia unit in a respectful and supportive manner. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care, as sighted on files reviewed.  All resident files reviewed, identified that informed consent is collected. Interviews with staff confirm their understanding of informed consent processes.  The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discuss informed consent processes with residents and their families/whānau during the admission process.  The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives. The general practitioner makes a clinical decision around resuscitation and ongoing treatment for residents who are not able to make an advance directive (and have no advance directive documented in the past) and the advance directive is discussed with the family and/or enduring power of attorney (EPOA) prior to the doctor signing the form. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged.  Staff training on the role of advocacy services is included in training on Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) – last provided for staff in 2015.  Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked.  Families interviewed confirm they could visit at any time and are always made to feel welcome.  Residents are encouraged to be involved in community activities and to maintain family and friends networks. Residents are encouraged to maintain friendships already developed in the community. This was particularly noticeable in the dementia unit where both friends and family visited residents. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation’s complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Evidence relating to each lodged complaint is held in the complaints folder.  Two complaints reviewed in 2015 indicate that the complaints are investigated promptly with the issues resolved in a timely manner.  Residents and family members state that they would feel comfortable complaining.  There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The business and care manager, clinical manager or a registered nurse discuss the Code, including the complaints process with residents and their family on admission. Discussions relating to the Code can also be held at residents’ meetings, as sighted in 2015 meeting minutes reviewed. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes information around rights and this can be produced in a bigger font if required.  Information is given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members are able to describe their rights and advocacy services, particularly in relation to the complaints process.  Information about the Nationwide Health and Disability Advocacy Service is displayed in the foyer of the service and in the dementia unit. |
| 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 a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident’s support needs are assessed using a holistic approach. The initial and on-going assessment gains details of people’s beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner, with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.  The service ensures that each resident has the right to privacy and dignity. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility (both in the rest home and dementia unit) which can be used for private meetings.  Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm that residents’ privacy is respected.  The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports for 2015 or on incidents reviewed in resident files. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect.  Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service implements the Māori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. The service continues to try to develop links to local kaumātua and Māori services but can also access support through the district health board. There are staff who identify as Māori and staff report that specific cultural needs are identified in the residents’ care plans. There are Māori residents currently using the service and they have a cultural assessment and plan in place.  Staff are aware of the importance of whānau in the delivery of care for the Māori residents. |
| 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 | The service identifies each resident’s personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice. Staff are also able to describe how residents in the dementia unit have choice, for example, around what clothes to wear and what food to choose.  Residents and/or family are involved in the assessment and the care planning processes as sighted in files reviewed. Information gathered during assessment includes the resident’s cultural values and beliefs. This information is used to develop a care plan.  Staff are familiar with how translating and interpreting services can be accessed. Residents in the service do not require interpreting services, noting that one resident has family who visit daily, who can interpret, if required. There are cue cards also available for staff to use for this resident.  There is a focus on ensuring that individual activities encourage independence. This includes a focus on inclusion of activities that are meaningful for residents in the dementia unit with memory boards in each residents’ bedroom. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implements the Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care.  Job descriptions include: responsibilities of the position; ethics; advocacy and legal issues, with a job description sighted in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction include standards of conduct. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the health care assistants’ role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Heretaunga Home and Village implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all the Oceania facilities.  There is a training programme for all staff and managers who are encouraged to complete management training. There are monthly regional management meetings. Specialised training and related competencies are in place for the registered nursing staff, with a review of staff files indicating that these are completed annually by all staff, relevant to their role.  Residents and families interviewed expressed a high level of satisfaction with the care delivered.  Consultation is available through the organisation’s management team that includes registered nurses, the clinical and quality manager, regional operations manager and a dietitian. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health, or a change in needs, as evidenced in completed accident/incident forms.  Family contact is recorded in residents’ files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings.  Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All are signed on the day of admission.  Residents do not require interpreting services although staff are conscious of involving family for one resident in the dementia unit for whom English is a second language. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Heretaunga Home and Village is part of the Oceania Care Company Limited with the executive management team, including the chief executive, general manager, regional operations manager, and clinical and quality manager providing support to the service.  Communication between the service and managers takes place on at least a monthly basis with both the regional operations management and the clinical and quality manager providing support during the audit. The monthly business status and regional operations manager reports provide the executive management with progress against identified indicators.  There is a clear mission, values and goals. These are communicated to residents, staff and family, through posters on the wall, information in booklets and in staff training, provided annually.  The facility can provide care for up to 46 residents, including four studio apartments attached to the rest home, which have been confirmed at past audits as being able to support residents requiring rest home care. During the audit there were 41 residents living at the facility including 24 residents requiring dementia care and 17 requiring rest home care.  The business and care manager is responsible for the overall management of the service. The business and care manager has been in the role for over 20 years and has a national diploma in management, level five. The regional operations manager and the clinical and quality manager confirmed their support for the business and care manager on the days of audit. |
| 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 business and care manager, the clinical manager is in charge, with support from the regional operations manager, and clinical and quality manager (organisational). The clinical manager has been in the role for five years, is a registered nurse, and has over twelve years’ experience in aged care. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Heretaunga Home and Village uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. Head office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood.  Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme, with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data.  There are a range of meetings held to discuss data. These include monthly staff/quality meetings, clinical meetings and health and safety meetings. Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. There are also two monthly resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements and can have input into discussions and review of service delivery.  There is a six monthly family and resident satisfaction survey, with family and residents indicating that they are satisfied with care provided.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The business and care manager is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, infectious disease outbreaks, and changes in key managers.  Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.  Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed, with evidence of improvements put in place. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The registered nurse and the clinical manager hold current annual practising certificates along with other health practitioners involved with the service.  Staff files included appointment documentation, for example, signed contracts, job descriptions, reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.  All staff complete an orientation programme and health care assistants (HCAs) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks, including personal cares. HCAs confirmed their role in supporting and buddying new staff.  Annual competencies are completed by care staff, for example, hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. The organisation has a mandatory education and training programme. Staff attendances are documented. Education and training hours are at least eight hours a year, for each staff member, with the registered nurses training records indicating that they have had well in excess of eight hours training in the past year around clinical topics, for example, wound management, management of challenging behaviour and de-escalation and continence. |
| 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 staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy.  There are 40 staff, including the management team, clinical staff, a diversional therapist and activity staff, and household staff. There is always a registered nurse on a morning shift. The registered nurse and clinical manager are on call.  Residents and families interviewed confirm staffing is adequate to meet the residents’ needs. Staff confirm that they have sufficient time to complete cares scheduled. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.  There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.  Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation.  Resident files are protected from unauthorised access by being locked away in an office, either in the rest home or dementia unit.  Information containing sensitive resident information is not displayed in a way that it could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff interviewed state that they read the long term plans at the beginning of each shift and are informed of any changes through the handover process. |
| 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 | Residents’ entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Information packs are provided for families and residents to the rest home and the dementia unit, prior to admission. The facility requires all residents to have needs assessment service coordinators (NASC) assessments, prior to admission, to ensure they are able to meet the resident’s needs. Interviews confirm that the registered nurses (RNs) admit new residents into the facility. Evidence of completed admission records was sighted. The RNs receive hand-over from the transferring agency, for example, the hospital, and utilise this information in creating the appropriate long term care plan for the resident. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge, or transfer of residents is undertaken in a timely and safe manner. The CM reported that they include copies of the resident’s records including: GP visits; medication charts; current long term care plans; upcoming hospital appointments; and other medical alerts, when a resident is transferred to another health provider. |
| 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. | FA | Medicine management policies and procedures are in place and implemented, including processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner.  Medicine charts listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts were signed by the GP. All entries were dated and allergies recorded. All residents had photo identification. Discontinued medicines were signed and three monthly GP reviews were all completed within the three monthly timeframe. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily.  Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the rest home and the dementia unit. The staff members checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines, and then signed off after the resident took the medicines.  Staff were authorised to administer medications. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies. There were no residents who self-administer medicines. Medicines management training occurs for staff. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service policies and procedures are appropriate to the service setting, with seasonal menus reviewed by a dietitian. Residents’ dietary profiles are developed on admission, and reviewed six monthly, or when resident’s condition changes. There are current residents’ dietary profiles in residents’ files and copies in the kitchen. The kitchen staff are informed if resident's dietary requirements change. Interviews with kitchen staff confirm their awareness of the residents’ dietary requirements. Kitchen staff are trained in safe food handling and food safety procedures are adhered to.  Residents who require special eating aids are provided for, to promote independence. The residents' files demonstrated monthly monitoring of individual resident's weight. Supplements are provided to residents with identified weight loss. In interviews, residents stated they are satisfied with the food service. Residents reported their individual preferences are met and adequate food and fluids are provided. The residents’ meeting minutes’ evidence feedback about the food service is positive. The service provides additional food over a 24 hour period for residents with dementia.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a documented process for the management of declining resident’s entry into the facility. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services. The scope of services provided is identified in the admission agreement and communicated to prospective residents and their families. The clinical manager (CM) assesses the suitability of residents and uses an enquiry form, with appropriate questions regarding the specific needs and abilities of each resident.  When residents are not suitable for placement at the service, the family and or the resident are referred to other services, depending on their level of needs. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The resident’s needs, support requirements, and preferences are collected and recorded within required timeframes. The RNs or the CM complete a variety of risk assessment tools on admission. The service completes interRAI assessments for all new residents.  Additional assessments were sighted in the residents’ files including the medical assessment completed by the GP and recreational assessment completed by the activities coordinators (ACs). Baseline recordings are recorded for weight management and vital signs with monthly monitoring.  Staff interviews confirmed that the families are involved in the assessment and review processes. The outcomes of the assessments are used in creating an initial care plan, the long term care plan, and a recreational plan, for each resident. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The person centred care plans (PCCP) are resident focused and integrated. The residents’ files had sections for the resident’s profile, details, observations, PCCPs, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable and clearly documented. The service recorded intervention for the achievement of the goals. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents’ receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the PCCPs. Multidisciplinary meetings are conducted to discuss and review long term care plans. Residents’ files reflected residents and family involvement in the development of goals and review of care plans.  Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist. |
| 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 | The activities programmes confirm that independence is encouraged and choices are offered to residents. The diversional therapist (DT) and activities coordinators (ACs) develop and implement the activities programmes. The service had no residents under the age of 65 at the time of the audit.  Activities include: physical; mental; spiritual and social aspects of life, to improve and maintain residents’ wellbeing. During the onsite audit, activities included: residents going for an outing; music; and one-on-one activities. Residents and family confirmed they were satisfied with the activities programme.  On admission, the ACs complete a recreation assessment and plan for each resident. The recreation assessments and plan include: personal interests; family history; work history; and hobbies, to ensure resident’s participation in the activities. Residents’ files reviewed during the onsite audit had six monthly activity reviews completed. Residents in the dementia unit had 24 hour activity care plans for managing challenging behaviours, on file. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents’ files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from the GP, RNs, health care assistants, the ACs, and other members of the allied health team.  Daily progress notes are completed by the health care assistants and RNs. Progress notes reflect daily response to interventions and treatments. Residents are assisted in working towards goals. Short term care plans are developed for acute problems, for example, infections, wounds, falls, and other short term conditions. |
| 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 | The CM stated that residents were supported in access or referral to other health and disability providers. The RNs manage referrals for residents to the GP; dietitian; physiotherapist; speech language therapist and mental health services. The GP confirmed involvement in the referral processes. The review of residents’ files included evidence of recent external referrals to the physiotherapist and specialists. |
| 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 and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read, and are free from damage.  Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances.  There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example, goggles/visors, gloves, aprons, footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed – expiry date 17 August 2016. There have been no building modifications since the last audit.  There is a planned maintenance schedule implemented. Equipment is available, including shower chairs and sensor alarm mats. There is an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually.  Interviews with staff and observation of the facility confirms there is adequate equipment.  There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables. There is an internal secure courtyard and external garden area that is secured for residents in the dementia unit. Both have seating and shade. |
| 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 adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.  Residents and family members report that there are sufficient toilets and showers.  Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified. |
| 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 is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment, staff and the resident.  Rooms could be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the suite their own. The dementia unit has bedrooms that are reflective of the lives of the resident.  There is room to store mobility aids, such as walking frames, in the bedroom, safely during the day and night, if required.  Some residents have a larger room to accommodate specific aids. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has lounge/dining areas, including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.  There is a dining area in the rest home and one in the dementia unit with ample space for residents. Residents can choose to have their meals in their room.  Residents in the dementia unit and rest home are encouraged to join other residents for meals and for social engagement. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry, with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. Residents and family members state that the laundry is well managed, apart from one family member who had some issues with missing and damaged clothes. The health care assistants interviewed confirmed knowledge of their role including management of any infectious linen.  There are cleaners on site during the day, seven days a week. The cleaners have a trolley to put chemicals in and the cleaners are aware that the trolley must be with them at all times. This was observed in the dementia unit particularly. All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. The cleaner interviewed confirmed that they had training at least annually.  Cleaning and laundry is monitored through the internal audit process with no issues identified in audits. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan was approved by the New Zealand Fire Service in 2003. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.  There is always at least one staff member with a first aid certificate on duty.  All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas BBQ’s.  An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells. Call bell response times checked by the auditors on the day of the audit were answered promptly.  The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.  There is a gas boiler to heat water and this has last been checked by an external company in October 2015.  There are no residents who smoke, however, there is a designated external smoking area for residents, should this be required.  Family and residents interviewed confirm the facilities are maintained at an appropriate 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 | The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The infection control committee has representatives in each area of the service management team. This group meets monthly and infection control matters are discussed at the monthly staff and quality meetings. There is an infection control programme that was last reviewed in March 2015.  When a resident presents with an infection, staff send specimens to the laboratory for sensitivity testing. The GP prescribes antibiotics as per sensitivity, confirmed during interview. The RNs create short term care plans and review the effectiveness of the prescribed antibiotics when the treatment is completed. Infections are discussed during staff meetings, sighted in meeting minutes. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate human, physical, and information resources, to implement the infection control programme and meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing. The facility maintains regular in-service trainings for infection control, including standard precautions, personal protective equipment, cleaning, infectious diseases and hand washing. Sighted training records that are aligned with the training planner. |
| 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 | Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements, and are readily available and implemented at the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The organisation provides relevant education on infection control to all service providers, support staff, and residents. Specialised training is provided for the ICC relating to the management of outbreaks, including online education and training sessions provided by the Ministry of Health (MoH). The infection control education is provided by either the infection control coordinator (ICC) or external resource speakers. Residents interviewed were aware of the importance of hand washing. Staff members confirmed receiving infection control training and could explain the importance of hand washing in the prevention and control of infection. |
| 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 | The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.  Information gathered is clearly documented in the infection log, maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.   The infection control surveillance register includes monthly infection logs and antibiotics use. The organisation had an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Staff interviewed, observations, and review of documentation, demonstrated that there is no use of restraint or enablers in the service. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a restraint register. The restraint coordinator is the clinical manager (CM). |

# Specific results for criterion where corrective actions are required

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

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

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

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| 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.