# Experion Care NZ Limited - Greendale Residential Care Centre

## Introduction

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

The audit has been conducted by Health 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](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:** Experion Care NZ Limited

**Premises audited:** Greendale Residential Care

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

**Dates of audit:** Start date: 1 February 2016 End date: 2 February 2016

**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:** 21

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

Greendale Residential Care Centre is a 27 bed facility for rest home level of care residents. This provisional audit was undertaken to establish the prospective provider’s preparedness to provide a health and disability service and the level of conformity with the required standards of the existing owner’s services.

The audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, interviews with residents, family/whānau, management, staff, a general practitioner and the prospective provider’s representative.

There are three areas for improvement in relation to medicine management, first aid qualifications for staff and the review of the infection control programme.

The prospective provider has owned another aged care service in New Zealand for approximate five months. The prospective provider has a nurse manager, who is their representative in New Zealand.

## Consumer rights

The residents receive services that respects their rights. The current staff and prospective owner’s representative demonstrated knowledge and awareness of their obligations of consumer rights legislation. The residents are treated with respect, dignity and are not subject to abuse, neglect or discrimination.

There are appropriate processes and procedures implemented to ensure residents who identify as Maori, or any other culture, have their individual beliefs respected and acknowledged. If required, the service can access an interpreter.

The service provides an environment that encourages good practice, which should include evidence-based practice.

Residents and families receive full and frank information and open disclosure from staff. The residents, their families or enduring power of attorneys (EPOAs) are involved in the care planning, decision making and consent processes. Where there is an advance directive, the staff act on the decisions.

There are no set visiting hours and residents have access to visitors of their choice. All visitors commented on the welcoming nature of the service.

The service has a documented complaints management system which was implemented. There are no outstanding complaints at the time of audit.

## Organisational management

The current owners and management have a business and quality plan in place. The organisation’s mission statement, vision, goals and philosophy identifies the organisation’s mission statement, vision and philosophy. The prospective provider and their representative have a transition plan to review all current systems and documents in the first month, if any changes are to be made, these will reflect the ongoing compliance with the standards and contractual requirements.

The current quality and risk system and processes support safe service delivery and include corrective actions. The quality management system includes identification of hazards, staff education and training, an internal audit process, complaints management, data reporting of incidents/accidents and infections. The day to day operation of the facility is undertaken by non-clinical and clinical staff who are appropriately experienced and/or qualified. This allows residents' needs to be met in a safe and efficient manner, as confirmed during resident and family/whānau interviews and in the 2015 satisfaction survey results.

Policies and procedures are managed by a contracted agency and the prospective provider will review these.

The service implements the documented staffing levels and skill mix. The rosters record that there are adequate staff each shift to comply with contractual requirements. Not all shifts are covered by at least one staff who has a current first aid qualification. Human resources management and education processes are implemented and identify good practice is observed. The prospective provider owns another aged care service and their representative demonstrates a good understanding of human resources requirements.

Resident information is uniquely identifiable, accurately recorded and securely stored. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

## Continuum of service delivery

The entry requirements for rest home level of care are clearly documented. Residents and families receive accurate information on admission to the service. If entry to the service is declined, a record is maintained and the potential resident and/or their family/whānau referred to a more appropriate service.

The processes for assessment, planning, provision, evaluation, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. The service has implemented the required electronic assessment tool (interRAI). The care plans described the required support and/or intervention to achieve the desired outcomes. The evaluation record showed the progress the resident is making towards meeting their goals. Where progress is different from expected, the service responds by initiating changes to the care plan or with the use of short term care plans. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

Referral to other health or disability service providers is appropriately facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessments to facilitate any discharge or transfers to other providers.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents.

There are processes in place for a safe medicine administration. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. The medicine fridge temperature requires regular monitoring and the three monthly review of medicines needs to be recorded on the medication chart.

The families and residents report satisfaction with the meal services. The menu is reviewed by a dietitian.

## Safe and appropriate environment

Services are provided in a clean, safe, secure environment that is appropriate to rest home level of care. There are appropriate amenities to meet residents’ needs and to facilitate independence. Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Laundry and cleaning services are conducted by onsite staff. There are adequate toilets, showers, and bathing facilities.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness. Planned and reactive maintenance is documented. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan.

All residents have access to outdoor areas with shaded areas.

The prospective provider has no plans to change any service or environmental areas in the near future.

## Restraint minimisation and safe practice

The service operates a restraint free environment. Staff undertake annual restraint minimisation education so they have a full understanding of what is required should restraint be used. This was discussed with the prospective provider on the day of audit to ensure understanding of this process.

## Infection prevention and control

There are appropriate systems in place for infection prevention and control. The infection control coordinator attends and provides regular staff education related to infection prevention and control. The documented policies and procedures for the prevention and control of infections are regularly reviewed. The infection control programme has not been reviewed within the last year.

Surveillance for infections is conducted monthly. Results of surveillance are collected, collated and analysed to identify any trends and prevent or minimise further infections. The prospective purchaser intends to keep the current policies, procedures and surveillance processes.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 2 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. New residents and families were provided with copies of the Code as part of the admission process. Staff demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The residents' files reviewed had consent forms signed by the resident or their next of kin/enduring power of attorney (EPOA). The files contained copies of any advance care planning and the resident’s wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them. Residents and family expressed no concerns related to informed consent.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The residents and family/whanau reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is conducted as part of the in-service education programme.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | There are no set visiting hours and visitors are encouraged to visit. The residents and families reported that the service is ‘like a second family’ and feel very welcomed to visit. Residents are supported and encouraged to access community services with visitors. Some residents and family did comment that they thought there could be a greater amount of outings, with the service already identifying this and reviewing actions that can be implemented to make improvements to this.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The sighted complaints policy and process complies with Right 10 of the Code. Complaints management is explained as part of the admission process and is included in the information given to new residents and family/whānau. Complaints management is included in new staff orientation and included in ongoing training. Family/whānau confirmed that the house manager’s open door policy makes it easy to discuss concerns at any time. The complaints register identifies complaints have been managed within policy time frames. There were no open complaints at the time of audit. The prospective owner’s representative understands the consumer’s right to make a complaint. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The Code is discussed with family members at the time of admission and information is also available in the information booklet. Information was also displayed about the Nationwide Health and Disability Advocacy Service. The families reported no concerns about the staff not respecting the resident’s rights. The prospective owner’s representative demonstrated awareness of the Code and is planning to attend education specific to aged care. The prospective provider was not available for interview.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are three shared rooms (currently used as single rooms), with all other rooms being single rooms. The curtain tracks are in place in the shared rooms and the dividing curtains are able to be hanged if the rooms are to be shared. The residents have a privacy sign that they put on their doors that indicates that staff cannot come into their bedroom unless they are invited to enter by the resident. The files reviewed reflected that care is provided that is responsive to the individual cultural and spiritual needs of each resident. The services are planned so the residents can maintain as much independence as possible. The relatives reported satisfaction with the care provided and have no concerns about abuse or neglect. Staff demonstrated knowledge on identifying any suspected abuse and know who to report to if they suspect abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | Residents who identify as Maori have their individual needs met. The clinical manager reported that there were no barriers to Maori residents accessing the service. The staff demonstrated knowledge of the importance of whanau in the care and support of residents who identify as Maori. There are no current residents that identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The resident’s individual cultural values and beliefs were recorded in the care plans. All files evidenced the care was developed in consultation with the family. The relatives interviewed reported that the service meets the individual needs of their relatives. Staff demonstrated knowledge in respecting and meeting the individual cultural needs, values and beliefs of each of the residents. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff individual employment contracts have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whanau reported they have no concerns about discrimination. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. There is regular in-service education and staff access external education that is focused on aged care and best practice. This included pressure area prevention in December 2015. Staff reported that they were satisfied with the relevance of the education provided. Best practice with wound management was sighted in a resident's file reviewed, who had a long term wound prior to admission, which is now showing signs of healing. The residents and family/whanau expressed high satisfaction with the care delivered. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service promotes an environment that optimises communication through the use of interpreter services as required. Staff education has been provided related to appropriate communication methods. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documentation of open disclosure following incidents/accidents is evident. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service has a maximum capacity of 27 residents. There are four shared rooms that the current provider is using as single rooms. On the day of audit 21 beds were occupied, all are rest home level of care and includes one younger person under the age of 65. The service has a business plan which identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs. The prospective provider is aware that the direction and goals of the organisation need to be reviewed regularly, as evidenced with interview with their representative. The quality policy statement identifies the mission of the organisation and the procedures undertaken to achieve the mission statement. The prospective provider’s representative reported and the transition plan documented that in the first month they will review the current systems, compare them to the systems that the prospective provider has, take the best approach from these systems to implement a consistent quality and risk approach across this and their other facility. The prospective provider’s representative and transition plan records that the representitive, who is a manager of the provider’s other aged care service, will oversee the transition plan records and transition period. Any changes are documented that these will be compliant with the standards and the contractual requirements. If changes to management are to occur, the new provider will ensure that there is an appropriately skilled and experienced person perform to ongoing management of the service.The service is currently managed by a house manager, who has managed the service for over 12 years and has a background in aged care. The house manager has completed a certificate in rest home management. The house manager is supported by two registered nurses (RNs) who are responsible for the oversight of clinical care and an office/financial manager for other non-clinical aspects and maintenance side of service delivery. The RNs are on site seven days a week. The house manager has attended more than 8 hours’ education in the past 12 months related to management of aged care services and receives regular updates from an aged care consultant. The residents and families have high praise for the care and services provided at Greendale and all have high praise for the house manager, with comments such as the house manager goes ‘the extra mile’ in their responsibility to provide a ‘homelike, friendly and family orientated’ environment. An external satisfaction survey records that residents and family are ‘extremely satisfied’ with the care and support they receive at Greendale.  |
| 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 | Currently during a temporary absence of the house manager, the office/financial manager and RNs take on the house manager’s roles. The house manager reports confidence in the staff’s ability to take on the management role during temporary absences. The prospective provider intends to review the management structure in the first month of operation. If any changes are to be made, these will be complaint with contractual requirements. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service is a family owned business, with the owners being the directors. There have been recent changes to this with the death of one of the directors. The service has a business plan and quality and risk process in place which covers all aspects of service delivery. Quality planning identifies generalised goals and objectives and the measure used to identify how the controls are effective or responsive to resident needs. This includes quality data collection and analysis to identify any areas of deficit which are addressed using corrective action processes. Corrective actions sighted related to internal audits, complaints, environmental issues, care planning, and identified risks. All findings are shared with the director and data findings are shared with staff at monthly staff meetings as identified in minutes sighted. Quality data information is used to inform the ongoing improvement and planning of services. The prospective provider will review all systems in the first month and ensure that any changes that may be made will reflect contractual requirements and the needs of the residents.Policies and procedures are developed by an aged care consultant and personalised to the service. Any changes or newly introduced policies are shared with staff at the monthly staff meetings. Staff confirmed that they understand and implement documented quality and risk processes. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management.Staff, resident and family/whānau confirmed services are provided to meet residents’ needs and examples of quality improvements were given.Actual and potential risks are identified and documented in the hazard register. The hazard register identifies all known hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. |
| 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 managers and clinical staff fully understood their obligations in relation to essential notification reporting and know which regulatory bodies must be notified as identified in policy. The pressure injury policy is being reviewed to ensure the essential notification of stage 3 and above pressure injuries and are included in the essential notification procedures. Incident and accident information is shared with all staff and any corrective actions that have been taken are evaluated. Family/whānau is notified of any adverse, unplanned or untoward events at all times. This was identified on incident and accident forms sighted and in resident files reviews. Family/whānau interviewed confirmed they are kept ‘well informed’ of any concerns the staff may have or of any adverse events related to their relatives. This was also observed at the time of audit after an incident/fall occurred. The prospective provider’s representative is a nurse manager of another aged care service and understands their responsibilities for essential notification and incident/accident reporting and will oversee the transition period. If there is any change to the management of clinical staff, essential notification requirements will be included in any orientation period.  |
| 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 | Staff that require professional qualifications have them validated as part of the employment process and annually.Human resources policies describe good employment practices that meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities. Staff complete an orientation/induction programme with specific competencies for their roles, such as medication management, as confirmed during staff file reviews. The prospective provider’s representative understands the need for ongoing education for all staff and will review the existing education calendar set out for 2016 and make changes as required. Any changes made will reflect the contractual requirements and the needs of the residents.Education records sighted identify that staff education includes on-site planned education with topics being presented by the gerontology nurse specialist and off-site seminars and training days.Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents’ needs are met by the service.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | The service has a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs. Rosters sighted identify that the skill mix is based on and exceeds the contractual requirements for staffing levels for rest home care. There is also at least two care staff on duty at most times (at night there is one on-site and one staff member on call). At the busiest times of the day (between 7am to 10am) there are up to 4 care staff on duty, some of these staff then go onto do cleaning, laundry and activities duties after this time. The RN on call role is shared between the two RNs. The on-site caregiver at night has a personal alarm that can connect to emergency services (such as ambulance and police) when activated. A night staff member reported they always have access to a RN during their shift if required. The prospective provider will review the skill mix in the first month of operation. Any changes made will be compliant with the contractual requirements and ensuring the needs of the rest home level of care residents. Staff are replaced for annual leave or sick leave. Staff verbalised that they have sufficient time and staff to complete their required duties. The care staff assist with the laundry service and there are specific cleaning, cooking and activities roles to adequately meet the needs of residents. Residents interviewed stated all their needs have been met in a timely manner. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files identified that information is managed in an accurate and timely manner. Health information was kept in secure areas in the staff area and these were not accessible or observable to the public. There was no private information on display in the facility. All records pertaining to individual residents demonstrated they are integrated. The archived records are securely stored onsite. The resident’s progress notes have entries each morning and afternoon shift and recorded the staff member’s signature. The service has identified and implemented actions (sighted in staff meeting minutes and interviews with staff) to ensure that the staff also consistently record their name and designation as well as their signature. A signature verification log is also kept. As the service has already commenced making improvements to this, a corrective action has not been given as a systemic issue was not identified.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The household manager oversees entry to the service. The enquiry form records all enquires and if the potential resident has an appropriate assessment for rest home level of care. The resident information handbook contains accurate information about the service. All residents’ files contain an appropriate needs assessment for rest home level of care. The service updates any vacancy on the Eldernet website each weekday.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | When admission has been required to the acute care hospital, the service utilised the DHB’s transfer form/envelope. The referral process documented any risks associated with each resident’s transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. Along with the transfer form/envelope, the RN reported that the service also provides a copy of any other relevant information.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | The observed medication procedures are implemented to meet legislative and best practice requirements. The prospective owner intends to keep the current systems for medicine management. The medications are stored in the locked medication trolley. Medications that require refrigeration are stored in a medication fridge, through the temperature for this has not been regularly recorded. The processes for controlled drug management meet requirements. There are no standing orders or residents who self-administer their medications. There are policies and processes in place if a resident is assessed as competent to self-administer their own medications. The medications are individually prescribed for each resident. There is no bulk supply of medications. The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy by the RN. The medication charts and prescriptions have the required information and are either hand written by the GP or a pharmacy generated medication chart that is signed by the GP. The three monthly medication reviews are recorded in the residents file and not on the medication chart. All staff who administer medications are assessed as competent to do so. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a four-week rotational menu that has summer and winter variations. This menu has been reviewed by a dietitian in the last 12 months. Residents with specific nutritional needs have these met. The kitchen staff receive a copy of the nutritional requirements for each resident. Residents are routinely weighed monthly or more frequently if there is a clinical need. Nutritional supplements are available to residents assessed as requiring these. The RN and resident/family reports there have been no issues with unintentional weight loss. The kitchen services are based on the food safety principles. There are appropriate processes in place for the purchasing, preparation and disposal of food that complies with current legislation and guidelines. The kitchen staff (and a resident who volunteers in the kitchen) have food safety training.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The household manager reported if the service is to decline entry to a potential resident, this is recorded. When entry is declined, the referred, prospective resident and family are informed of the reason why. The admission agreement is developed through an aged care association that is then personalised to the service. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service only provides rest home care to residents assessed as requiring secure dementia care, should the needs of the resident increase beyond this level, the resident is reassessed and referred to a service that is better able to meet the higher level of need. The service has had occasions where residents have been required to transfer to a service providing dementia, psychogeriatric or hospital level of care. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The assessments and reassessments are conducted using the electronic interRAI assessment process. All files have an initial interRAI assessment. The service also uses their own paper based assessments for additional needs that are identified through the assessment process; this includes behaviour assessments, nutrition, falls, wound assessment, pressure injury risk. There is a summary of the assessed needs of the resident and these are then documented on the care plan. The files record and residents/families report that the care provided meets the resident’s needs.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident’s specific needs, goals/aims and staff interventions required to address those needs. The care plans evidenced family consultation and input into their planning. The residents and family/whanau report satisfaction with the care and with specific management of their relative’s medical conditions.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The provision of services and interventions are consistent with meeting the needs of the residents. The resident’s records are individualised and personalised to meet the assessed needs of the resident. The care was observed to be flexible and focused on promoting quality of life for the resident’s. All the residents and family/whanau reported satisfaction with the care and service delivery. |
| Standard 1.3.7: Planned ActivitiesWhere 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 residents are included in meaningful activities at the care facility. There is an activities coordinator Monday to Friday and staff assist with the planned and diversional activities over the weekend. The staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents. The activities programme covers physical, social, recreational and emotional needs of the residents. The residents were observed to be participating in meaningful activities both inside and out in the grounds of the service. The families reported overall satisfaction with the level and variety of activities provided, though did comment that they thought there should be greater amount of outings. Residents were observed to be going offsite with family/friends. There is one younger resident who has age appropriate activities and has regular outings to community activities or goes out with family.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluations are conducted at least six monthly and recorded on the care plan. The service has processes in place to use the built in evaluation scores when the service reassess the resident using the interRAI assessment and record this on their own paper based evaluation record. None of the records reviewed have required an evaluation since this component of interRAI became compulsory from January 2016. The current care evaluations are conducted for all the resident’s needs and recorded how the resident’s goals have been met over the past six months. When there are changes in the resident’s needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Each of the residents maintain their own GP if available. The GP arranges for any referral to specialist medical services when it was necessary. The resident’s files have appropriate referrals to other health and diagnostic services.  |
| 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 | All chemicals are securely stored. Chemicals are clearly labelled and safety data sheets are available. Staff confirmed that they can access to personal protective clothing and equipment at any time. As observed, disposable gloves and gowns were worn when required. Waste storage and disposal meets legislative requirements. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current warrant of fitness. Maintenance is undertaken by both internal maintenance staff and external contractors. Electrical safety test tags show this has been conducted within the last 12 months. Clinical equipment is tested and calibrated at least annually or when required.The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, and walking areas are not cluttered. If any areas of concern are identified in the environmental audit the issue is placed in the hazard register if it cannot be eliminated. This identifies how the hazard is managed. There is access to external seating areas and gardens. Residents were sighted moving around safely both indoors and outdoors on the days of audit. Residents and family/whānau confirmed the environment is suitable to meet their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | Residents’ shower and toilet areas are centrally located. The doors have privacy locks to ensure residents can attend to their personal hygiene without interruption. There is a designated staff/visitor toilet. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. Results from the relatives satisfaction survey and family/whānau members interviewed did not identify any concerns related to personal bed space or privacy. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. The dining and lounge areas are separated. The areas are appropriately furnished to meet residents’ needs. Residents and family/whānau voiced their satisfaction with the homely environment. As observed, activities are undertaken in the lounge area.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are secure storage areas for cleaning and laundry equipment. The facility looked clean and was odour free, with the residents and family all commented on how well the service is cleaned and their laundry is looked after. The cleaning and laundry processes monitored for effectiveness through satisfaction surveys and reporting by the chemical provider.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The night staff have an emergency personal alarm that alerts the emergencies services when activated. The approved evacuation scheme. The service has not commenced renovations at the time of audit and the current evacuation scheme applies. The building is fitted with fire sprinklers, indicator panel and has adequate fire equipment. The service has a civil defence kit, first aid kits and outbreak supplies. The service has adequate food and water for a minimum of three days. There are adequate torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly. Fire suppression systems are maintained and inspected monthly by the external contractor. The service has a call bell system in all resident areas. There is an audible alert and a light above the room where the call bell is activated. The residents and family/whanau report a timely response to the call bells. |
| 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 | The facility is kept at a suitable temperature throughout the year by electric heating, heat pumps/air conditioners and the opening of doors of windows for ventilation. This was confirmed during resident and family/whānau interviews. All resident areas have at least one opening window to provide adequate natural light. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | PA Low | An RN is the designated infection control coordinator (not available for interview at the time of audit). They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meeting, at which the senior management are present. The directors are informed of quality, risk and infection control issues. Although the policies and procedures have been reviewed within the last 12 months, the review of the infection control programme was not sighted. The prospective purchaser intends to review the infection control processes in the first month of ownership. There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advice relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. The staff demonstrated good knowledge and application of infection prevention and control.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control matters are discussed at the staff meetings conducted monthly. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can access this through the DHB, GP or diagnostic services. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies and procedures have been developed by an aged care consultant. They cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. The policies and procedures were last reviewed in 2015 (refer to 3.1.3 regarding the policy recording a requirement for a two-year review of the infection control programme, this needs to be updated to reflect the standards) These policies are appropriate to the services offered by the facility. All staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator conducts most of the infection control education. There are some visiting specialists who provide infection control education. The house manager and RN reported that the current infection control coordinator demonstrated current knowledge in infection prevention and control. The infection control coordinator has attended ongoing education on current good practice in infection prevention and control. As required infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene when assisting with toileting. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is monthly collection, collation and analysis of infections. The service uses standardised definitions, applicable to aged care, to identify infections. The type of surveillance undertaken is appropriate to the rest home level care service. Data is collected on urinary tract infections, influenza, skin infections and respiratory tract infections.The infection data reviewed for 2015 records the collation, analysis, graphing and trending of the infection data. The analysis includes comparisons with the previous month, reasons for any increase or decrease and actions, advice and recommendations for reducing infection occurrence. The outcomes are feedback to the staff at the next staff meeting. The infection surveillance records include the review and analysis of an outbreak that occurred in 2015. These record that the service had done ‘extremely well’ to minimise the spread of the outbreak and it was resolved quickly.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is no recorded restraint or enabler use. The organisational policies indicate the service is committed to providing a restraint free environment. There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers will be voluntary and the least restrictive option to meet the needs of the resident to promote independence, comfort and safety. Staff demonstrated knowledge of what a restraint is, enablers and what to do if they were required. Staff undertake annual education related to restraint minimisation and were able to verbalise de-escalation methods used to prevent any restraint use. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.8.1There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | The two staff that regularly do night shift do not have a current first aid qualification. Both have expired first aid certificates and are booked in for the course in February 2016. As a personal alarm system connects to the ambulance service when activities the risk rating for this has been reduced to moderate.  | The two staff who regularly work night shift do not have current first aid qualifications.  | Ensure there is at least one staff member on each shift that has current first aid qualifications. 60 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The medicine fridge temperature does not evidence consistent weekly recording of temperature. The temperature of the fridge was within the required guidelines at the time of audit. There is an area of improvement to ensure that the temperature is consistently recorded at least weekly. The service has commenced implementing this at the time of audit.The three monthly medication reviews by the GP are being recorded in the residents’ clinical file and not on the medication chart. There are contractual requirements that these reviews are recorded on the medication chart. The service has commenced addressing this, and has now got a medication chart template that has a section for the three monthly reviews to be recorded.  | The three monthly medicine reviews are recorded in the resident’s files and not on the medication chart.The medicines fridge has not had the temperature monitoring consistently recorded.  | Provide evidence that the ongoing recording of the three monthly medicine reviews are being recorded on the medication chart and the medicine fridge temperature is recorded weekly. 180 days |
| Criterion 3.1.3The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | There was no evidence that the infection control programme has been reviewed in the past 12 months. There is a documented review of an outbreak that occurred in March 2015, this is specific to the actions implemented for the outbreak. There was no overall review of the infection control programme as a whole that has occurred within the last 12 months, which indicates that the infection control programme is meeting its goals. The infection control polices records that the review of the infection control programme is 2 yearly. The infection control coordinator’s job description records the infection control programme is required to be reviewed annually.  | The annual review of the infection control programme was not sighted.  | Provide evidence that the infection control programme is reviewed at least annually. 180 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

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End of the report.