# Well Health Care Limited - Fencible Manor Rest Home

## Introduction

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

The audit has been conducted by The DAA Group 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:** Well Health Care Limited

**Premises audited:** Fencible Manor Rest Home

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

**Dates of audit:** Start date: 14 January 2016 End date: 14 January 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:** 18

# 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

Fencible Manor Rest Home provides rest home level care for 18 residents and is privately owned by Well Health Care Limited. The service is managed by the registered nurse owner. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, the manager, staff, and a general practitioner.

There are no areas for improvement required from this audit.

## 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 interviewed demonstrated good knowledge and practice of respecting residents’ rights in their day to day interactions. The manager is fully informed of the obligations of the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Rights (the Code). Education is provided to all staff at orientation and is ongoing. Advocacy and interpreter services are available if required.

There were no residents who identified as Māori at the service at the time of the audit. There are no known barriers to Māori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written informed consents are obtained as required. Signed informed consent forms were sighted in all residents` records reviewed.

Linkages with family/whānau and the community are promoted and encouraged.

There is a documented complaints process in place that complies with the Code. There are no outstanding complaints.

## 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. |

A business plan and quality and risk management plan is documented and includes the mission and goals of the service. There is a process in place for the regular reporting against these goals.

The facility is managed by an experienced and suitably qualified manager, who is the registered nurse and owner of the facility.

Quality improvement data is collected and discussed at staff meetings and staff were able to describe this. There is an internal audit programme and internal audits have been completed. A corrective action plan is in place. Adverse events are documented and there is evidence of good follow-up of these. Open disclosure is documented, as appropriate, as it occurs.

There are policies on human resources management. Practising certificates are current for RNs and associated health professionals. Staff files have the required information, including staff education records. Staff report good access to training. Staff turnover is low and an orientation programme is in place.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. The facility manager and senior staff are rostered on call after hours. Care staff reported there are adequate staff available.

The privacy of residents’ information is maintained in a secure manner. Residents’ files are well presented and easy to navigate.

## 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. |

Pre-admission information accurately identifies the service offered. The service agreements are signed and dated appropriately.

Services are provided by suitably qualified and skilled staff to meet the needs of the residents. The interRAI assessment process is well implemented. All residents have had an interRAI assessment performed. Timeframes for the development and review of the long term care plans are met. Short term plans are developed when there are changes in the resident`s needs that are not addressed on the long term plan.

The general practitioner reviews all residents medically at the required timeframes and more frequently as needed. Referrals to other health and disability services are planned and coordinated, based on the individual needs of the resident.

The activities programme meets the social and recreational needs of the residents. Activities are planned and are meaningful to residents. Residents are encouraged to maintain links with the community and the family/whānau.

A safe medication system was observed during the audit. The staff responsible for medication management have completed comprehensive competencies to perform this role.

The residents` nutritional requirements are met by the service with preferences and special diets being catered for. The staff who prepare meals are all experienced and prepare meals from a menu plan which has been approved 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. |

The building complies with legislation with a current building warrant of fitness displayed. A preventative maintenance programme includes equipment and electrical checks and redecoration. The environment is appropriate to the needs of the residents.

Residents’ rooms allow for care to be easily provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. A call bell system allows residents to access help when needed and residents stated that they are answered in a timely manner.

## Restraint minimisation and safe practice

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

The service has documented policies and procedures for restraint minimisation and safe practice. The service operates a ‘no restraint policy’. Staff confirmed that enabler use would be voluntary and the least restrictive option. No residents were using enablers at the time of the audit.

Environmental restraint is in practice by locking of external doors for security. There are good processes in place around this, including signed consent by all residents. Staff demonstrated a sound knowledge and understanding of restraint and the use of enablers.

## Infection prevention and control

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

The infection prevention and control management system is appropriate for the nature of this service. The programmed is reviewed annually and implemented. Infection prevention and control reduces the risk of infections to residents, staff, families/whānau and visitors. Policies and procedures are available to guide staff. Staff are provided with relevant education, as are residents, when appropriate.

The registered nurse infection control coordinator collates monthly surveillance data and reports this to the manager. Where any trends are identified action are implemented. The infection surveillance results are reported at the staff monthly meetings. Expertise is available and can be sought as required.

## 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 | The Code of Health and Disability Services Consumers` Rights (the Code) is displayed in the reception area of the rest home in full view of residents, healthcare assistants and visitors to the facility. The service manager interviewed stated that the rights of residents are respected.  Staff receive training on the Code at commencement of employment as part of the orientation/induction process. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice.  The Code is available in English and Māori and other languages for residents with English as a second language. |
| 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 | Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate informed to make informed choices and informed decisions. The registered nurse interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and understand informed consent processes and that appropriate information had been provided.  Policies and procedures implemented are available to guide staff.  A multipurpose informed consent form is utilised by the service provider and a copy is retained in each of the resident`s records reviewed. Some additional forms sighted included the annual influenza vaccination consent forms, photograph identification consent and consent to be part of the GP’s primary health organisation and practice concerned. Forms reviewed were signed and dated appropriately. Full explanations were provided by the registered nurse and/or the GP.  The manager was responsible for the service agreements being signed and dated appropriately. These were stored separately in the manager`s office securely and confidentially.  The GP interviewed understands the obligations and legislative requirements to ensure competency of residents as required for advance directives and reviews are undertaken six monthly.  The registered nurse interviewed reported that education is provided on the principles and practice of informed consent as part of the Code of Rights. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy policy is available to guide staff. All residents receiving care at this facility have appropriate access to independent advice and support, including access to a cultural and/or spiritual advocate as required.  Family interviewed reported they were provided with all relevant information regarding access to advocacy services. The contact details of the Nationwide Health and Disability Advocacy Service is in the resident information pack provided on entry to the service. The contact numbers are also documented on the reverse of the Consumers` Rights brochure. Staff education is conducted as part of the orientation programme for all new employees and is ongoing as evidenced in the education plan and confirmed by staff interviewed. |
| 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 | Family/whānau/friends are encouraged to visit at any time and family are able to participate in the activities programme if they wish to do so. Outings with family members are encouraged and resident are able to enjoy outings each fortnight in the community as arranged. Family are invited to join the residents on special event days.  Families interviewed reported that they are kept well informed. The family communication record in the front of each resident`s record sighted evidences families are contacted by staff if any significant changes occur. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The manager is responsible for complaints and there is a system in place to manage the complaints process. A complaints register is maintained that included two minor complaints since the new manager’s appointment in April 2015. Both complaints were managed appropriately.  The complaints policy is compliant with Right 10 of the Code. Systems are in place to ensure residents and their families are advised on entry to the facility, of the complaints process and the Code. Residents and family demonstrated an understanding and awareness of these. Review of the staff meeting minutes provided evidence of reporting of complaints to staff. Staff confirmed these discussions at staff meetings. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and the registered nurses go through the Code with the resident/family/whānau during the admission process.  The family members that were available to interview reported that the Code was explained to them on admission. Interviews with residents who were able to provide insight into their care, expressed that they were treated with the utmost respect and were happy at the rest home.  An interpreter service is available through the Counties Manukau District Health Board (CMDHB). Contact details are readily accessible to staff if and when required. Staff are also available to translate in Mandarin if applicable. The registered nurse and senior healthcare assistants interviewed displayed knowledge of the Code and demonstrated respect to all residents. |
| 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 privacy policy requires that the visual privacy and personal space of residents is to be respected and observed at all times. The wishes of residents are acknowledged, sexuality and personal rights are upheld, and independence maintained, maximised and encouraged. The general practitioner interviewed reported that visits are conducted for each resident in their own individual rooms and privacy is respected.  The residents` records reviewed indicated that residents received appropriate services that were responsive to their needs, values and beliefs of culture, religion and ethnicity.  The families interviewed reported satisfaction with the way the service meets the needs of their relatives. Church services are provided weekly at the facility. A family member/minister interviewed is available as an advocate and to speak with residents as required. The minister visits on a regular basis.  No concerns were raised in relation to abuse and neglect from residents, the general practitioner (GP), family and/or staff interviewed. Staff have received education and understood their responsibilities along with who to report to if abuse/neglect was suspected with a resident or a staff member. Comments received reflected a positive atmosphere from staff and family. |
| 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 has a Māori Health Plan and Tikanga Best Practice Policy which acknowledges the Treaty of Waitangi and states the service will provide an appropriate and effective health service for Māori people. The manager interviewed is committed to identifying the needs of residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of any barriers are part of the Māori Health Plan objectives sighted.  Guidelines are developed and implemented to ensure guidance is available for the provision of culturally safe services to Māori. There are no known barriers that exist for Māori residents to access this service. There are currently no residents that identify as Māori or staff that identify as Māori.  The registered nurse and senior healthcare assistants interviewed demonstrated good understanding of services that would need to be provided for Māori residents to meet identified needs, and the importance of whānau. |
| 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 spiritual, religious and cultural policies and procedures provide information to guide staff on the correct protocol. A cultural needs assessment tool is available to ensure the identified needs can be effectively met. The manager and registered nurse interviewed have an understanding for promoting health and wellness for all residents.  Staff interviewed reported they received training in cultural awareness and respected all cultural needs in their everyday practices. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff records reviewed contained job descriptions and employment agreements that have clear guidelines regarding professional boundaries. House rules are also part of the employment agreement and staff responsibilities are documented. There are clear definitions of types of discrimination in policy sighted. There are key objectives to be upheld for all residents.  The manager is a registered nurse and along with the other two registered nurses employed have completed the professional boundaries workshops in 2015 which is a requirement for the New Zealand Nursing Council. The family/whānau/residents interviewed reported they are pleased with the care and management provided. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The RN manager and two registered nurses promote and encourage best practice with staff. Evidence of this was demonstrated during the audit with medication management and purchase of a new medicines trolley and a new wound care management trolley with the latest resources being readily available.  Policies and procedures are managed effectively by a contracted quality consultant with extensive experience in the aged care sector.  The general practitioner interviewed is pleased to have discussions with family if and when required and to visit residents as needed. The family and residents interviewed reported satisfaction with the services and care provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is clearly documented to include communication principles. Resident and family have a right to know what has happened to them and to be fully informed. There is a family/whānau communication record in the front of all residents’ files reviewed.  The cultural appropriate policy documents that residents and families who do not speak English shall be advised of the availability of an interpreter or an advocate at the first point of contact with the service.  The service promotes an environment that optimises communication and staff education related to appropriate communication methods. The GP interviewed spoke highly of the staff and the excellent communication and relationship between them and the GP and also the effective communication with the contracted pharmacist.  Families interviewed confirmed they are kept informed of the resident`s status, including any adverse events adversely affecting the resident. Evidence of open disclosure is documented in the residents` records reviewed and on the incident/accident form. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service mission is displayed in the facility and is known by staff. The business plan was sighted which defines the scope, direction and goals of the organisation as well as the monitoring and reporting process against the goals.  There are eighteen rest home beds available at this facility and eighteen beds are occupied on the day of the audit. One resident included is on the respite contract, but is assessed as rest home level care.  The facility manger is the registered nurse (RN) owner, who took ownership of the business in April 2015. Prior to this she worked as a RN in the facility for three years. The owner uses a quality consultant for mentorship and guidance and belongs to appropriate professional bodies. Since taking over the facility she has made a number of quality improvements that have streamlined processes. Both staff and families reported an improvement in the service since the change of management. |
| 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 facility manger the senior RN deputises for the facility manager. The senior health care assistant is the designated assistant manager and is rostered on during the manager’s absence. Both staff members confirmed their responsibilities in these roles. There are good electronic processes to keep in touch remotely. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management plan was reviewed and is used to guide the quality programme. Purpose, goals, and objectives are included in the plan and there is evidence in the staff meeting minutes that progress on these goals is reported bi-monthly.  Policies and procedures are relevant to the scope and complexity of the service and reflect current accepted good practice. All documents are controlled and there is a process underway to improve this process. All staff have been made aware of the policy updates and there is evidence in the staff meeting minutes where the manager has informed staff of these and there has been training at the meetings on individual policies. There has been one new staff member since the new management and this person confirmed that the policies are part of her orientation.  Staff meet monthly and have a comprehensive set agenda that includes the required quality data and includes health and safety and infection control. The manager reported that this is discussed at meetings and staff confirmed the same.  Corrective actions are developed and implemented by prioritisation against risk and resources.  A health and safety manual is available. There is a hazard reporting system as well as a hazard register that identifies health and safety risk. |
| 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 | Adverse events are documented on an accident/incident form and these are followed up by the nurse manager. Forms are well annotated with follow up actions. Open disclosure is documented and it is noted on the form when family members have been informed. Incidents are discussed at the staff meetings.  Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.  The facility manager is aware of the essential notification requirements and these are documented in policy. The facility manager advised that there have been no notifications of significant events made to the Ministry of Health since the taking over the business eight months ago. |
| 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 | There are policies and procedures on human resources management. Annual practising certificates of RNs are available as are those for all associated allied health professionals. The skills and knowledge required for each position within the service is documented in job descriptions which are evident on each personal file. Individual records of education are maintained for each staff member and were reviewed. The manager is currently identifying the process for police vetting as she has only employed one new staff member in her tenure.  There is an education plan for the next two years with several sessions confirmed with speakers. The 2015 programme was reviewed and evidenced that education is provided, in house, on line and by staff visiting external facilities. All relevant staff have medication competencies.  An orientation process is available and covers the essential components of the service provided. The one staff member currently undertaking this found it to be informative and supportive. Staff performance is reviewed at the end of orientation and otherwise annually. Staff interviewed stated they had good access to education and that they enjoyed it. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on good practice. There are two registered nurses on duty each morning. There is an RN or senior health care assistant on call each day and the manager is on call at all times. Care staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them. Residents and families interviewed reported that there was enough staff on duty to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Personal information is entered in all residents` records reviewed. Records reviewed evidenced entries being documented which are legible with signatures and staff designations included. All individual records are integrated with divisions labelled accordingly. Residents’ records are stored in the manager`s office. Resident information is not displayed in public view without consent being obtained.  Staff records are maintained by the manager and stored confidentially in a filing cabinet. A system is in place for accessing archived records if and when required.  A resident register is maintained by the manager. |
| 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 manager has an enquiry book for recording all pre-admission enquiries. There is a resident`s information pack available. There is adequate information about the service provided along with the contact details of the service. The service agreement is based on the Aged Care Association agreement which is individualised to the service. The residents` agreements are signed and dated and stored separately in the manager`s office. The admission agreement identifies any additional charges that are not covered by the service agreement and the relevant costs of each change required.  All residents at the facility have been pre-assessed prior to admission as requiring rest home level care. The District Health Board Needs Assessor Service Co-ordinators (NASC) ensure the interRAI pre-assessment documentation is made available to the RNs when a resident is admitted. Residents can be directly admitted from Health Services for Older People or Mental Health Services for Older People from the DHB after relevant full assessment processes have been completed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The registered nurse interviewed stated that any risks identified prior to discharge or transfer are documented. A transfer form is used and the `yellow bag system`, a DHB requirement, is utilised. The registered nurse ensures open disclosure between services and family/whānau related to all aspects of service delivery occurs. This includes residents for either discharge and/or transfer to another facility or to the DHB.  If there are any specific requests or concerns that the resident or family want discussed, these are noted on the transfer form. The discharge summary and copy of the care plan summary is provided and covers all personal cares and needs of the resident and any interventions required. Any identified risks, alerts, concerns are highlighted. If a transfer occurs a copy of the medication record with any known allergies and/or sensitivities, the resident information record and any advance directives also accompany the resident, if they are transferred to hospital. If transferred to another facility a full interRAI assessment is required to be completed. Family are kept well informed throughout the process. |
| 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 | The medication policies are accessible to guide staff as required. The sighted policies meet legislative and best practice guidelines. The two registered nurses and two senior health care assistants are responsible for the medication management. The manager oversees this aspect of service delivery. All have completed medication competencies.  Medicines are received from the contracted pharmacy in a pre-packed delivery system. The medications are checked for accuracy by the registered nurses. The medications are stored in a locked cupboard and a medication trolley. There are no controlled drugs at the facility. A signature specimen list is available to verify signatures if needed. There is a clear process for any medication/incident events.  A safe system for medicine management was observed on the day of the audit. The GP interviewed stated that there have been no significant medication errors in which the GP has been involved. The registered nurses can contact the GP with any queries or points of clarification as needed.  The medication records randomly selected and reviewed have been reviewed by the GP on a regular basis and records are maintained. All medicines are prescribed individually on the records reviewed. Photographic identification is evident on all medication records. The medication signing records are generated from the pharmacy and as each medication is administered it is signed off by the staff member concerned. A system is in place for medication returns to the pharmacy. These are recorded and monitored.  The medication fridge is temperature monitored. There are no residents that self-administer medication. A policy is in place if required. |
| 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 cook interviewed was relieving on the day of the audit for the main cook. The main cook works Monday to Thursday and Sunday and the other days the second cook covers the service. The cook is well informed about food handling and practices to meet legislative requirements. The food safety management education undertaken is appropriate to service delivery. A menu audit was performed by a contracted dietitian two years ago. The manager will arrange for this to be re-done this year (2016). The dietitian is available on a referral basis. The menu plans are four weekly and summer and winter menus are prepared.  Policies and procedures and guidelines are available. Separate cleaning schedules and temperature monitoring requirements are met. The cook orders all food, checks deliveries, storage and manages the waste management appropriately. All food in the pantry is clearly labelled. The floor level is clear. The kitchen is well designed, clean and functional for the size of the facility.  A nutritional assessment is undertaken for all residents by the registered nurse on admission. A copy of this assessment is provided to the cook. Any preferences, special diets, likes/dislikes are documented. Special days are celebrated, such as birthdays, and catered for by the cook.  Annual service satisfaction surveys completed by residents/family included the food service. The families and residents interviewed reported satisfaction with the meal service. |
| 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 RN interviewed reported that the service does not refuse a resident if they have a suitable needs assessment service co-ordinators assessment completed for the level of care required. The service has arrangements with the DHB to provide predominantly rest home dementia care.  In the event that the service cannot safely meet the needs of a resident, the resident, family and the NASC service are contacted so that alternative residential care can be arranged. This could occur, as an example, in the event of a resident requiring a secure dementia service for ongoing dementia care. The GP and/or the manager interviewed would ensure the appropriate referrals for re-assessment are arranged. The resident register would be up-dated if a resident is discharged to another facility. The registered nurses are responsible for completing an interRAI assessment when required. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An interRAI summary is evident in all residents’ records reviewed. Any additional assessments, as required, are completed by the registered nurses, such as risk assessments, pain assessments and cultural assessments and others depending on identified needs for the individual resident.  Results of the assessments are discussed with the resident, staff and families and included in the care plan as needs with appropriate interventions in place.  Residents, staff and families interviewed reported appropriate care is provided that meets identified support needs and preferences. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents` records reviewed have care plans that address the resident`s abilities, level of independence, identified needs/deficits, and takes into account the resident`s habits and idiosyncrasies. The strategies minimising falls risk on assessment and use of techniques that are effective for managing challenging behaviour in the records reviewed are evident. The comprehensive interRAI assessment summary which includes triggered outcome scores and the needs, identified by the registered nurse completing the individual assessment. These finding are documented onto the existing care plan.  The manager and the registered nurse interviewed demonstrated they understand the interRAI process and this will be implemented for the reviews as documented.  The individual care plans and individual activities plans identified resident`s activities, motivational and recreational requirements with documented evidence of how these are managed effectively for each individual resident. The activities co-ordinator interviewed provided insight on how the activities interventions were developed to meet the needs for residents individually.  The residents’ records sighted demonstrated service integration and service delivery plans that were developed after appropriate assessments had occurred. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurses and healthcare assistants interviewed demonstrated appropriate skills and knowledge of the individual needs of all residents. The records reviewed showed evidence of consultation and involvement of the resident and family as able. The residents interviewed reported satisfaction with the care and services provided.  Short term care plans are developed as necessary for any event that is not part of the long term care plan, such as unexplained weight loss or wound care management. The registered nurses ensure the GP is kept well informed of progress.  The service has adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed demonstrated interventions that are consistent with the resident`s needs being able to be met. Observations on the day of the audit indicated residents are receiving care that is consistent with meeting their assessed needs. The registered nurse interviewed reported that all care plan interventions are accurate and are up-to-date. The two registered nurses are responsible for a number of residents from admission and in the longer term. The RN manager does not review the care plans. |
| 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 programme ensures resident`s individual motivational, recreational and cultural needs are recognised. Each resident is assessed by the activities co-ordinator on admission. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The activities co-ordinator interviewed reported how the activities programme is developed and implemented for this small rest home successfully.  The activities programme is planned monthly and displayed on a weekly basis. A copy of the programme is displayed in the dining room notice board. Residents and families can access the information displayed. The activities co-ordinator maintains attendance records. Each resident has their own activities plan which is reviewed six monthly or earlier if required. The co-ordinator is aware that resident participation is voluntary and this is respected.  Residents are encouraged to maintain links with family and the community. The service hires a bus fortnightly for outings in the community. Special days are celebrated. A display board is evident of recent Christmas and New Year celebrations at the rest home. A church service is held weekly. Communion is arranged to meet the needs of the residents.  At the time of the audit residents were visibly enjoying the activities in progress during the audit and residents interviewed reported that they enjoy the variety of planned activities arranged. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluation of the care plans occur six monthly or earlier as applicable. Evaluations are focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the set goals. If a resident’s needs change or if the resident is not responding appropriately to the interventions being delivered then this is discussed with the GP, the resident and the family. Short term care plans are initiated as needed.  The healthcare assistants interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover sessions between shifts. Progress is also discussed at the six monthly reviews.  Families reported that they are consulted when staff have any concerns or when there are changes to the resident`s condition. This is documented on the family communication records as evidenced in the records reviewed. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are provided with options if required to access other health and disability services. There is a GP who is contracted to the facility and the GP visits the service regularly. The GP covers the after-hours if required and covers twenty four hours a day seven days a week. The GP interviewed arranges any referrals to specialist medical or surgical services as required. There is a process for transferring residents if and when required. The DHB referral system (‘yellow bag’) is followed through and is a guide for the GP and staff after hours.  The registered nurse interviewed reported that referral services respond promptly to referrals sent. Records of the processes maintained was confirmed in residents’ records reviewed which includes referrals and consultations with eye specialists, orthopaedic specialists, geriatricians, mental health services for older persons, portable x-ray radiologists, nurse practitioners, mental health nurses, physiotherapist, podiatrist and/or dietitian services. The GP interviewed reported that appropriate referrals to other health and disability services are well managed. Copies of referrals are retained in the individual resident’s records. |
| 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 in a timely manner. Material safety data sheets are available in the laundry and accessible to staff. No products are decanted other than under the manufacturer’s instructions in the laundry for the automatic dispenser.  There is provision and availability of protective clothing which was observed in the bathrooms. Staff interviewed were aware of using protective clothing appropriately. |
| 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 that expires on the 22 March 2016. Review of documentation provided evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. There is a maintenance programme in place for the building, equipment, and renovation. Testing and tagging of essential equipment is current and on the maintenance plan. There are external areas available that are safely maintained and are appropriate for the resident group. The environment is conducive to the range of activities undertaken. Residents are protected from risks associated with being outside.  Residents interviewed confirmed and were observed to move freely around the facility and that the accommodation met their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Most rooms have a full ensuite with wet area showers, toilets, and hand-basins. Rooms without ensuites have hand basins and there are adequate numbers of communal bathrooms and toilets in close proximity to bedrooms. Appropriate secured and approved handrails are provided in all toilet/shower areas and other equipment/accessories are available to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate personal space provided to allow residents and staff to move around within their rooms safely. All bedrooms provide single accommodation. Residents spoke positively about their accommodation. Rooms are personalised with furnishing, photos, and other personal items. There is adequate storage for walkers and wheelchairs. |
| 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 | There are good spaces for residents to enjoy activities, dining and relaxing, that are easily accessible by everyone. Residents are able to access areas for privacy when required. Furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely. Residents reported they enjoy their environment. |
| 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 | All laundry is washed on site by care staff who demonstrated sound knowledge of the laundry processes. There are separate rooms for washing and drying of clothes. There is a lockable cupboard for all cleaning and laundry chemicals, and all are appropriately labelled. Cleaning and laundry processes are monitored through the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire plan approved by the Fire Service and is fitted with a sprinkler system. A fire drill is conducted six-monthly and results are sent to the Fire Service. The last drill took place on 12 December 2015 and records of attendance were sighted. The orientation programme includes fire and security training. There is a policy for emergencies that includes evacuation and security. Staff confirmed their awareness of emergency procedures.  There is always at least one staff member on duty with a current first aid certificate.  All required fire equipment was sighted on the day of the audit and has been checked, by an external company, within the 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, and gas for cooking.  There are call bells to alert staff in each bedroom and bathroom. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to 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 | Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All rooms have electric oil heaters. All residents’ rooms have good sized windows to provide natural light. |
| 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 service has a managed environment which minimises the risk of infection to residents, staff and visitors. The infection control programme is led by a registered nurse and overseen by the manager. The infection prevention and control programme is reviewed annually. The infection control nurse monitors all infections, uses standardised definitions to identify infections appropriately, and carries out surveillance monitoring of organisms, related to antibiotic use. Monthly records sighted are maintained. Infection prevention and control is presented at each staff meeting. Minutes were sighted.  The infection control co-ordinator (ICC) was not available for interview however, the registered nurse on duty fully supported the programme and had a good understanding of the early detection of suspected infections. The healthcare assistants interviewed reported how they notify the registered nurses of any concerns when caring for the residents. Shift handovers are a forum for reporting infections. Short term care plans are used, for example, for wound care and other infections. There is an infection record which is maintained by the infection control co-ordinator.  A process is identified in policy for the prevention of exposing others to infection. Staff interviewed knew when not to come to work and when to return. Signage is used in the facility as required. Sanitising hand gel is evident throughout the facility and there are adequate hand washing facilities for staff, visitors and residents.  The programme reviewed is appropriate for the size and nature of this aged care setting and services provided. |
| 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 | The registered nurse (ICC) has only been in this role for a short period of time. The ICC reports to the manager directly and to the staff meetings which are held monthly. Any trends or issues identified are reported to the staff. The ICC and the full time registered nurse interviewed are experienced nurses. The manager is also a registered nurse. External specialist advice is available from the general practitioner, the laboratory microbiologist and the infection prevention, and control nurse specialists at CMDHB can also be contacted as required. The GP interviewed is well informed of obligations and reporting systems if needed for notifiable infection outbreaks of disease or illness. There have been no outbreaks of infection since the last audit. Guidelines and a pandemic plan are in place should an incident arise. |
| 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 | The infection prevention and control programme has recently been reviewed. The objectives of the infection control programme are documented. Infection control policies and procedures are available to guide staff. Specific infection control areas, such as for surveillance, wound-care management, blood and body spills, cleaning and disinfectant are covered adequately. Standard precautions are adhered to throughout all areas of service provision.  Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection prevention and control education is included in the orientation programme for all staff and is part of the ongoing annual plan for 2016 which was reviewed. Infection prevention and control education is provided by the ICC, the registered nurse interviewed and the manager (RN). External trainers, for example product representatives for the cleaning, kitchen and laundry systems, provide additional education which is completed by all staff. The registered nurses can also attend additional education through the CMDHB infection prevention and control programme. The registered nurses and healthcare assistants interviewed demonstrated good knowledge of infection prevention and control.  Resident education is conducted as required. Hand hygiene is encouraged by all staff and management. |
| 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 infection prevention and control surveillance that is undertaken is appropriate to the size of this aged care setting as demonstrated in the infection control programme. All staff are involved. An infection form is completed as soon as signs and symptoms have been identified and given to the RNs. Monitoring is described in the infection control plan to describe actions to ensure residents` safety.  The ICC completes the monthly surveillance report. Monitoring occurs for any urinary infections, eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections as required. The monthly analysis includes comparison with the previous monthly, reasons for an increase or decrease of infections and action taken is reported back to staff at the staff meetings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service operates with a ‘no restraint practice’ but does have policy and procedures to guide staff in the safe use of restraint should it be required. The manager and the restraint coordinator discussed the alternatives to restraint and are clear about the process should anyone require restraint in the future. This was also confirmed in interviews with staff. The policy identified that the use of enablers is voluntary and the least restrictive option to meet the needs of the residents to promote independence and safety. Currently there are no residents using any enablers.  The service operates under an environmental restraint for the security of the residents. The home is fully fenced and the three external doors are locked at all times. There is a keypad by the front door with the number clearly displayed and this is accessible by everyone. The two other doors are alarmed, with push buttons to exit. All three doors open automatically in the event of a fire.  There is a signed consent form for this security on each person’s folder and the families and residents spoken with are clear about his procedure and its rationale. |

# 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.