# Vinada Limited - Voguehaven Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Vinada Limited

**Premises audited:** Voguehaven Rest Home

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

**Dates of audit:** Start date: 29 January 2016 End date: 29 January 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 22

# 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

Voguehaven rest home provides rest home level of care for up to 26 residents. On the day of the audit there were 22 residents including one resident receiving respite care. The three owner/directors have leased the business for the last five years. One of the owner/directors is a qualified caregiver. The owner/directors are responsible for the daily operations and are supported by a part-time registered nurse and long serving staff. The residents and relatives spoke positively about the care and supports provided at Voguehaven rest home.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

Improvements are required around complaints documentation, internal audits, survey results, accident/incident follow-up, InterRAI assessments, interventions, activity plan reviews and end cooked food temperatures.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

Voguehaven provides care in a way that focuses on the individual resident. There are implemented policies at Voguehaven to protect residents from discrimination or harassment. Cultural and spiritual assessment is undertaken on admission and during the review processes. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Information about the Code of Rights "the Code" and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Family/friends are able to visit at any time. Residents and family interviewed verified ongoing involvement with community. There is a complaints policy and an up-to-date complaints register.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Voguehaven is implementing a quality and risk management system that supports the provision of clinical care. The service has implemented policies and procedures from a recognised aged care consultant. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. The organisation has a two-year business plan in place with quality objectives linked to the quality improvement system. Quality, health and safety and infection control are set agenda items at the quality meetings and staff meetings. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. A staffing policy includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff on duty to safely deliver care within a timely manner.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents are screened and approved prior to entry to the service. There is an admission package available prior to or on entry to the service that includes information on the services provided at Voguehaven rest home. The registered nurse is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

The activities team provides an interesting and varied activities programme for the residents that include outings and community involvement. Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines completes annual education and medication competencies. The general practitioner reviews medication charts at least three monthly.

All meals are prepared on site. Individual and special dietary needs are catered and alternative options are available for residents with dislikes. A dietitian has reviewed the menu.

## Safe and appropriate environment

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| --- | --- | --- |
| 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 holds a current warrant of fitness. Rooms were individualised. External areas were safe and well maintained. The facility has a van available for transportation of residents. There are two wings each with a lounge and dining room. There were adequate communal toilets and showers. The service has implemented policies and procedures for fire, civil defence and other emergencies. There is a first aider on duty at all times. Fire drills have been conducted six monthly. Resident’s rooms, communal bathrooms and living areas all have call bells. Fixtures, fittings and flooring are appropriate for rest home level care. Cleaning and laundry services were maintained. Chemicals were stored securely. The temperature of the facility was comfortable and constant, and able to be adjusted in resident’s rooms to suit individual resident preference.

## Restraint minimisation and safe practice

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

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There were no restraints and two enablers in place. Staff have attended restraint/enabler training.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There are a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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 | 38 | 0 | 4 | 3 | 0 | 0 |
| **Criteria** | 0 | 86 | 0 | 4 | 3 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The service has available information on the Code of Health and Disability Services Consumers’ Rights. Advocacy pamphlets and the code of rights are clearly displayed at the main facility entrance. Five residents and two relatives interviewed confirmed that information has been provided around the code of rights. There is a resident rights policy in place. Code of Rights training was last completed in August 2015. Discussion with two caregivers identified all were aware of the Code of Rights and could describe the key principles. |
| 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 | Written informed consent is gained for general consents and was sighted in the five resident files sampled. Resuscitation advance directives had been signed by the resident where the resident was deemed competent by the general practitioner (GP). Residents interviewed confirm they were given good information to be able to make informed choices. The registered nurse (RN) and caregivers interviewed stated the family are involved with the consent of the resident. Enduring power of attorney (EPOA) documents are kept on the resident's file. Discussion with family identify the service actively involves them in decisions that affect their relative’s lives.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. Caregivers interviewed are aware of the residents’ rights to advocacy services and how to access the information.  |
| 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 | The service has an open visiting policy, and family and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that relatives and friends are able to visit at any time and visitors were observed visiting the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Low | The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of all complaints, both verbal and written by using a complaints book (register). Five complaints were received in 2015. Follow-up and resolution was completed. A shortfall was identified around completion of the complaints action forms. Residents and family members interviewed advised that they are aware of the complaints procedure. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | A welcome information folder includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The manager is available to discuss concerns or complaints with residents and families at any time. Residents and family members interviewed state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.  |
| 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 | The facility provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. Staff sign a privacy declaration on employment. Staff attended privacy and dignity in service in September 2015. The manager is the privacy officer and has an open door policy.  |
| 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 | There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The Māori health plan is written in English and Māori. The service has established a link with iwi through a local Māori elder/Kaumatua who provides advice for staff and advocacy for Māori. On the day of the audit there were no residents that identified as Māori. |
| 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 service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular onsite church services, spiritual visitors and attending other community groups as desired. Staff attended cultural awareness training in November 2015.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of a service code of conduct. Professional boundaries are defined in job descriptions. Staff are observed to be professional within the culture of a family environment. The registered nurse (RN) works within professional boundaries as defined by nursing council.Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with care staff and two owner/directors could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The management team (owner/directors) is committed to providing services of a high standard, based on the service philosophy of care. All residents and families commented positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant to provide a good level of assurance that it is adhering to relevant standards. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. Staff have a sound understanding of principles of aged care and state that they feel supported by management. Care staff complete competencies relevant to their practice.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promote an open door policy. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family. Six monthly resident care, family and resident food surveys are completed that provide feedback on all areas of the service (link 1.2.3.7). Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Voguehaven is a 26-bed rest home, which provides a homely environment. On the day of audit there were 22 rest home residents including one resident on respite care. Three directors (husband/wife and daughter) who have the responsibility of the daily operations, finance maintenance and to oversee the delivery of services, have leased the business for six years. One manager/director has an aged care national certificate and has considerable experience (14 years) in caring for the elderly. A part-time RN supports the manager/directors (12 hours a week). The owner/directors formally meet five times a year. The agenda includes health and safety, infection control, restraint, audit outcomes and quality initiatives. There is a current governance quality plan for 2015-2016, which is to be reviewed at the first committee meeting for this year. Goals identified included (but are not limited to) upgrade the accommodation and environment, retain effective staff members and meet training needs. There have been environmental improvements and replacement of equipment. The refurbishing plan is ongoing. Staff interviewed confirmed the communication levels are good and the staff work together as a team. Residents and families speak highly of the staff and the services provided. The Voguehaven owner/directors have attended at least eight hours of training relating to the management role. Voguehaven is a member of the New Zealand aged care association and attends training and updates as offered. The RN maintains relevant professional development hours. Current annual practicing certificate was sighted. The owner/directors are available on call for facility or staffing matters. |
| 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 | During the temporary absence of the owner/directors (husband/wife), the RN is the acting manager. The third director oversees the service.  |
| 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. | PA Low | There are organisational policies to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management committee responsibilities and internal audit schedule. Staff have input into the staff meetings. Minutes sighted evidence there is discussion around complaints, compliments, health and safety, infection control and quality initiatives and improvements. Staff interviewed state they are well informed and receive quality and risk management information such as accident incident graphs and infection control statistics. The management committee meetings held five times a year includes the directors, RN and representatives of each service. Each area such as health and safety, infection control and clinical provide reports. Internal audit results are discussed, however not all audits are completed as per schedule. Implementation of corrective actions is the responsibility of the directors. Clinical guidelines are in place to assist care staff with safe and timely delivery of care. Policies and procedures are reviewed regularly and include reference to InterRAI assessments where applicable. There is an annual staff training programme that is implemented and based around policies and procedures. Falls prevention strategies are in place, that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.Surveys completed are; resident care (June and November 2015), resident food survey (February and July 2015) and family survey (May and September 2015). The results have not been collated.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | PA Moderate | As part of risk management and health and safety framework, there is an accident/incident policy. There is evidence of month-by-month data collection including (but not limited to) falls, skin tears, medication and behavioural incidents. Falls management and prevention includes analysis of time and location. When an incident occurs the staff member discovering the incident completes the accident/incident form. Twelve accident/incident forms were reviewed. Five incident/accident forms reviewed for unwitnessed falls did not evidence RN involvement. Two family members interviewed state they are informed of incidents/accidents.  |
| 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 human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one administration person, one cook, one cleaner, one RN and one caregiver). The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. A current copy of the RN practicing certificate was sighted. An orientation programme includes organisational structure and policies and general information for staff. Staff are orientated to their area of work and complete competencies relevant to their role. Staff interviewed stated that new staff are adequately orientated to the service. A documented in-service programme for education covers compulsory training requirements. Caregivers are encouraged and supported to undertake external education.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents’ needs. The manager (owner/director) and the housekeeper are qualified caregivers and provide cover between shifts from 1.00 pm to 2.30 pm. There are two caregivers on morning shift and afternoon shift. There is one caregiver on nightshift. The RN works for six hours on Tuesdays and Thursdays and is also on-call 24/7. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Residents interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the resident’s individual record and resident register. Resident clinical and allied health records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.  |
| 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 | Prior to entry, potential residents have a ‘needs assessment’ completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of the service. The admission agreement reviewed aligns with the ARC contract and documents any additional charges.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.  |
| 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 | Medication policies align with accepted guidelines. The RN and caregivers responsible for the administration of medications have completed annual competencies and medication education. Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. There were no self-medicating residents on the day of audit. Standing orders were not in use. Verbal orders taken are signed off by the GP within 48 hours as sighted in the medication folder. The service has good communication and access to the GP at the medical centre. The RN works part-time as a practice nurse for the medical centre ensuring the GP follows up/prescribes medication requests. Ten medication charts and administration signing were reviewed. Prescribing of medication met legislative requirements. A caregiver was observed administrating medications and compliant in the medication administration procedure.  |
| 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.  | PA Low | All food is prepared and cooked on-site at Voguehaven rest home. There is a qualified cook Monday to Friday and a weekend cook. They have completed food safety units and chemical safety. There is a four weekly rotating summer menu in place. A dietitian has audited the seasonal menus April 2015. The food is prepared in a central kitchen and served directly to residents in both dining rooms. The cook receives resident dietary profiles and is notified of any dietary changes and requirements. Dislikes are accommodated. Diabetic desserts and soft foods are provided as required. Fridge and freezer temperatures were recorded daily, however end cooked food temperatures are not taken. All foods were date labelled and stored correctly. A cleaning schedule is maintained. Residents interviewed commented positively on the meals and home baking.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service would record reasons for declining entry to residents should this occur and refer the resident/family/whānau back to the referral agency.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Nursing and risk assessments reviewed have been completed in timely manner using recognized tools to assess the resident’s needs. One RN is InterRAI trained and the other was at InterRAI training on the day of audit. Long-term residents have had six monthly InterRAI assessments completed. Risk assessments where applicable had been reviewed six monthly. The long-term care plans reviewed did not reflect the outcome of the assessments (link 1.3.5.2). InterRAI assessments had not been completed for new admissions (link 1.3.3.3).  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | I all files reviewed, the long-term care plan is completed within three weeks of admission by the RN. Care plans describe the resident goals, supports and interventions required to meet desired goals, however there was a shortfall around documented supports and interventions for residents with identified falls risk, pain and behaviours. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Resident files reviewed identified that family were involved. There was evidence of allied health care professionals involved in the care of the resident. Short-term care plans are used for changes in health status.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident’s health status. Resident files reviewed included a communication with family record, which evidenced family notification for infections, accident/incidents, GP visits, care plan reviews and any changes to health status.Staff report there are adequate continence supplies and dressing supplies. On the day of the audit, supplies of these products were sighted. There were no skin tears, wounds or pressure injuries being treated on the day of audit. Wound assessments and evaluation forms are available for use for wound care management as required. Staff have attended pressure injury prevention and management July 2015. The RN has attended wound care education. The RN interviewed could describe the referral process to a wound specialist or continence nurse.  |
| 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. | PA Low | The delivery of the activity plan is shared between the administrator (for documentation), a designated caregiver who incorporates activities into their day as a caregiver and one owner/director who is the van driver for two weekly outings/drives. The Monday to Friday programme is flexible and provides a variety of activities that are meaningful to the residents. The residents have a choice of a morning (10.30 am to midday) and afternoon (1.00 pm -3.00 pm) activity. Entertainment, movies, pampering, crafts, walks and exercises are included in the programme. Residents are encouraged to maintain links with community groups such as clubs, RSA visits, concerts, card groups and attending concerts/musicals. Special events/theme days are held and birthdays celebrated. Families are invited to happy hours. Visitors include schoolchildren, piano playing (volunteer) and a lay preacher who also offers weekly communion. Residents are supported to attend their church. Each resident has an individual activity plan, however the review does not happen at the same time as the clinical care plan review.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The RN has evaluated initial nursing assessment/care plans in resident files reviewed within three weeks of admission. Long-term care plans are reviewed at least six monthly by the RN and resident or family with input from the care staff and GP. Families are invited to attend the MDT meeting. Evaluations are dated and documented if resident goals are met or unmet. Short-term care plans have been reviewed by the RN and either resolved or added to the long-term care plan if the problem is ongoing. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The RN could describe the referral process to other medical and non-medical services. Referral documentation was maintained on resident files. The service provided an example of where a resident’s condition had changed and the resident had been reassessed for a higher level of care, for example from respite care to rest home level of care. |
| 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 | There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemicals are stored safely throughout the facility. Chemical product use and safety data sheets are available. Gloves, aprons, and goggles are available for staff. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Staff have received education in chemical safety.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness, which expires on 1 April 2016. The owner/directors have a reactive and planned maintenance programme in place. One/owner director is responsible for the daily maintenance of the facility and the planned maintenance plan. There has been ongoing upgrading of the facility including replacement of carpets, refurbishment of rooms as they become vacant, upgrading of the external areas, gardens and grounds. Hot water temperature checks were conducted and recorded monthly. An external contractor has serviced medical equipment annually. Electrical equipment has been serviced two yearly. Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access with ramps and rails to outdoor areas which provide seating and shade. Interviews with staff confirmed there was adequate equipment to provide safe and timely care.  |
| 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 | There are 22 single rooms and 2 double rooms. All rooms have hand basins. There are adequate numbers of toilets/showers for each wing of bedrooms. The toilets and showers are identifiable and include vacant/in-use signs. Showers have privacy curtains in place. Fixtures, fittings and floor and wall surfaces are made of accepted materials for ease of cleaning. Residents interviewed state their privacy and dignity is maintained while staff are attending to their personal cares and hygiene.  |
| 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 | Bedrooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed report that rooms have sufficient space to allow cares to take place. The bedrooms are personalised. The bedroom furnishings and seating were appropriate for the resident group.  |
| 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 | There was a lounge and dining room at each end of the home. The main dining room is adjacent to the kitchen area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed report they can move freely around the facility and staff assist them if required.  |
| 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 | All laundry is completed on site. There are designated cleaning staff, and care staff assist with laundry duties. The laundry had defined clean/dirty areas and an entry and exit door. The chemical provider monitors the effectiveness of laundry processes. Residents and relatives expressed satisfaction with cleaning and laundry services.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. Civil defence supplies include adequate water and food for three days. There is a barbeque and spare gas bottles. A generator, petrol, lights and leads, and torches are available for emergencies. The owner/director responsible for maintenance completes training and education for employees on the use of emergency equipment. Interviews with caregivers confirm staff are aware of emergency and security procedures. The service has an approved evacuation plan. Fire drills have been conducted six monthly. Resident’s rooms, communal bathrooms and living areas all have call bells. Residents are orientated to the call bell system on admission to the facility. The main entrance door is locked and accessible by call bell access. The keypad code is clearly displayed for visitors and residents to exit the home during the day. There is a silent alarm that can be activated to alert staff in the event of intruders.  |
| 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 | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated.  |
| 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.  | FA | The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The RN holds the infection control coordinator role. An infection control programme is linked into the quality management system. The infection control programme was reviewed July 2015. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine.  |
| 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 | The RN/infection control coordinator and two owner/directors are the infection control committee. The committee meeting is integrated with the staff meetings. The infection control coordinator has attended external education on infection control within the last year. The infection control coordinator has access to GPs, local laboratory, the infection control and public health departments at the local DHB for advice.  |
| 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 include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures were reviewed July 2015. Staff confirmed they are informed when there is a change to policy or infection control practice. External expertise can be accessed as required, to assist in the development of policies and procedures.  |
| 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 is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene and hand washing audits are completed annually and incorporated into the medication competency. Resident education is expected to occur as part of providing daily cares as appropriate. |
| 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 a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infections are collated monthly. Infection rates have been low. Trends are considered and discussed at the staff meetings. Infection rates are graphed and available to staff. The surveillance of infection data assists in evaluating compliance with infection control practices. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.There have been no outbreaks.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Voguehaven rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The owner/director and RN share the restraint coordinator role. The restraint coordinator confirms that the service promotes a restraint-free environment. There are no residents assessed as requiring restraint. There were two residents using enablers (cot sides). The two resident files reviewed evidenced assessment, consent and six monthly review of enabler use. All enablers in use were voluntary. Restraint education is included in the two yearly training programme. Restraint/enablers are discussed at the staff meeting. The caregivers interviewed were knowledgeable in the use of enablers.  |

# 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 1.1.13.1The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | The service records all verbal and written complaints received into a complaints register. Complaints were addressed and resolved to the satisfaction of the complainant. The policy includes the use of a complaints action form to complete the complaints procedure.  | Complaint action reports have not been completed for the five complaints made in 2015. | Ensure that complaints are documented in the complaint action report. 90 days |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | PA Low | An internal audit schedule is in place to include (but not limited to) clinical, environmental, documentation, medication, food services, cleaning and laundry service. Not all audits have been completed. Annual resident and relative surveys for 2015 have been completed but not collated or followed up to identify any areas for improvement. Results have not been collated/fed back to the participants.  | 1) The 2015 internal audit schedule has not been followed. 2) Survey results have not been collated and the results have not been communicated to the residents/relatives. | 1) Ensure the internal audit schedule is followed. 2) Ensure survey results are followed up and communicated to participants. 90 days |
| Criterion 1.2.4.3The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | All incidents are reported on the incident/accident form. Seven incident/accident forms identified RN involvement and follow-up.  | Five of 12 accident/incident forms were for unwitnessed falls. There was no evidence of RN notification, follow-up or sign off on the accident/incident form as per protocol.  | Ensure the RN is notified of all unwitnessed falls and documentation reflects follow up.30 days |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | All food is stored and dated in the pantry, fridges and freezers. Meat is placed at the bottom of the fridge. Kitchen and facility fridges and freezers temperatures are taken and recorded daily. Poultry is required to have end-cooked temperatures taken and recorded as per policy. Poultry is on the menu at least once a week. Internal kitchen audits are completed every three months and end cooked temperatures taken for three consecutive days however, poultry is not always listed as one of the meats audited.  | End cooked temperatures on poultry are not taken and recorded as per policy.  | Ensure end-cooked food temperatures are taken and recorded as per policy. 60 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | The RN completed InterRAI competency in June 2015. Long-term residents have had InterRAI assessments completed as part of their six monthly care plan review. There have been three new admissions since 1 July 2015. One of the three residents has had an InterRAI assessment completed within 21 days of admission.  | Of the five files reviewed, one resident had been admitted since 1 July 2015 and did not have an InterRAI assessment completed. The file sample was extended to include the two other residents admitted since 1 July 2015. Two of three new resident admissions since 1 July 2015 have not had an InterRAI assessment completed.  | Ensue all new residents have an InterRAI assessment completed within 21 days of admission. 60 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Risk assessments have been completed on admission in all resident files sampled. The care plans describe the supports and interventions required around activities of daily living, for example, skin integrity, continence, mobility and nutrition. A shortfall was identified around required supports for residents identified as high falls risk, identified pain and behaviours.  | Care plans did not reflect the supports and interventions required to achieve outcomes of assessments for (i) falls prevention strategies for five of five residents identified as high falls risk, (ii) pain management plans for four of five residents who identify pain, and (iii) interventions and management for one resident with known behaviours.  | Ensure care plans describe the required supports and interventions identified by the assessment process. 30 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Residents have an activity assessment completed on admission. An activity plan is developed in consultation with the resident and/or family that meets the resident’s individual recreational, social, physical, intellectual, spiritual and cultural needs and supports. The care plan is reviewed six monthly by the caregiver and administrator.  | The activity plans are not reviewed at the same time as the care plans as per ARC contract D 16.3 g iii. | Ensure activity plans are reviewed at the same time as the care plan. 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.