# Agape Care Limited - Milton Court 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:** Agape Care Limited

**Premises audited:** Milton Court Rest Home

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

**Dates of audit:** Start date: 13 April 2016 End date: 14 April 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:** 31

# 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

Milton Court Rest Home is privately owned and operated. The rest home provides rest home and dementia level of care for up to 36 residents. On the day of the audit there were 31 residents.

The director is the manager and a registered nurse with a current practicing certificate. She is supported by a full-time registered nurse and long serving staff. The residents and relatives spoke positively about the care and supports provided at Milton Court 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 family, management, staff and the general practitioner.

Improvements are required around quality data in meeting minutes, internal audit corrective actions, completion of adverse event forms, evaluations and medication fridge temperature monitoring.

## 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. |

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the entrance. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented and complaints and concerns are managed appropriately.

## 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 low risk. |

Milton Court Rest Home is implementing a quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. The education planner included mandatory educational requirements.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

A registered nurse is responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach were evident in the resident files reviewed. The general practitioner reviews residents at least three monthly.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the rest home and dementia care residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and senior healthcare assistants who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritious snacks are available 24 hours.

## 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. |

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are an adequate number of communal shower and toilet facilities. The dementia unit is secure and provides a safe indoor and outdoor environment for residents. There is safe access to all communal areas. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a first aider on duty at all times.

## Restraint minimisation and safe practice

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

The service maintains a restraint-free environment. There are policies and procedures to follow in the event that restraint or enablers are required. There were no residents using restraints or enablers. Staff have attended education on restraint, dementia and delirium within the last year.

## 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 (registered nurse) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There is 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 | 41 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 4 | 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 | Five residents (rest home) and relatives (two rest home and two dementia level of care) interviewed confirmed that information has been provided around the Code of Rights and their rights are respected when receiving resident related services and care. There is a resident rights policy in place. Discussion with one registered nurse and two healthcare assistants (HCAs) (who work across the rest home and dementia care unit) identified they were aware of the Code of Rights and could describe the key principles of resident’s rights when delivering care. |
| 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 | The service has in place a policy for informed consent and resuscitation. Completed resuscitation forms were evident on all resident files reviewed. There is documented evidence of discussion with resident/family when clinically indicated ‘not for resuscitation’ has been signed by the GP. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms etc. Enduring power of attorney evidence is sought prior to admission and is filed with the admission agreements. |
| Standard 1.1.11: Advocacy And Support  Service 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 Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) and advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the facility entrance. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receives education and training on the role of advocacy services. Care staff interviewed were aware of the resident’s right to advocacy services and how to access the information. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. Rest home residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending 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. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the manager (privacy officer) using a complaints’ register. There have been no complaints for 2015 since the previous audit. There have been two complaints to date for 2016. The complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidence resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents and family members advised that they were aware of the complaints procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes. Concerns/complaints forms are available at the front entrance. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service has available information on the Code of Health and Disability Services Consumers’ Rights. The Code of Rights (in English and Māori) is clearly displayed at the main entrance to the rest home. There is a welcome information folder that includes information about the Code of Rights. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission with the manager. The manager and RN are available to discuss concerns with residents and families at any time. Residents and relatives state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them or their relatives. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service 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 confidentiality clause on employment. Staff attends privacy and dignity and abuse and neglect as in-service training as part of their annual training plan. Resident’s cultural, social, religious and spiritual beliefs are identified on admission and included in the residents’ care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relative. Care staff state they promote resident independence with daily activities where appropriate. |
| 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 | There is a Māori health plan and cultural safety policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. The Māori health plan identifies the importance of whānau. On the day of the audit there were no residents that identified as Māori. Care staff were able to describe how to access information and provide culturally safe care for Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Residents are encouraged and supported to attend church services and other community groups as desired. |
| Standard 1.1.7: Discrimination  Consumers 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 were observed to be professional within the culture of a family environment. Staff have been trained to provide a supportive relationship based on sense of trust, security and self-esteem. Registered nurses are supported to attend district heath board (DHB) training as offered. Interviews with HCAs 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 Practice  Consumers receive services of an appropriate standard. | FA | Management are committed to providing services of a high standard, based on the service philosophy of care and shared values. This was observed during the day with the staff demonstrating a caring attitude towards the residents. All residents and families interviewed spoke positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant that adhere to relevant standards. Care staff and RNs also have access/reference to aged care best practice guidelines. Staff has a sound understanding of principles of aged care and state that they feel supported by management. Monthly meetings enhance communication between the teams and provide consistency of care. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promote an open door policy. Relatives were aware of the open door policy and confirm on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through three monthly resident and relative meetings and annual surveys. Meeting minute’s evidence previous matters are discussed and closed out as concerns are resolved. Accident/incident forms reviewed evidenced relatives had been informed promptly of any incidents/accidents. Relatives interviewed state they are notified of any changes to resident’s health status and are kept well informed.  Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. An interpreter service is available if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Milton Court Rest Home provides rest home level of care and dementia level of care for up to 36 residents. There are 16 rest home beds and 20 dementia care beds. On the day of audit there were 15 rest home residents and 16 residents in the dementia unit. There was one younger person under a long term chronic health condition contract. All other residents were under the ARCC.  Milton Court is privately owned and operated by one director/joint owner of the company since 2014. The owner is the manager and a registered nurse (RN) with a current practicing certificate. The other joint owner has responsibilities for the building maintenance and is the facility health and safety officer. The owner/RN is responsible for the daily operation of the business and is on-site Monday to Friday and shares the on call with the other RN.  The manager is supported by a full-time registered nurse who has been at Milton Court since graduation in 2014.  There is an annual business plan in place for 2016 which identifies the philosophy of care, mission statement, business objectives and specific aims for the service. The 2015 business goals and objectives have been reviewed. Achievements and quality improvements for 2015 were the establishment of management meetings, external painting, refurbishment of three bedrooms, replacement of carpet in the hallway of the dementia care unit and replacement of carpet with vinyl in one wing of the dementia care unit. Some goals that had not been fully achieved have been included in the 2016 business plan/objectives.  The manager has maintained at least eight hours annually of professional development related to managing a rest home and dementia care facility. Professional development includes interRAI training, attendance at a three day dementia care study day and attending district health board manager meetings three times a year. The manager is a Careerforce assessor. |
| 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 manager there is an agreement with another manager in the area to provide management cover. In the event of the other manager being unavailable an agency will provide a suitable manager. |
| 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. | PA Low | The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that are developed by an external consultant and reviewed regularly. A review log is at the front of each policy manual that evidenced reviews in November 2015.  Staff meetings are held monthly and include quality improvement, infection control and health and safety. Monthly manager, RN and supervisor meetings have commenced. Meeting minutes for both meetings did not evidence discussion around quality data. An annual internal audit programme is in place and audits have been completed as scheduled. Audit corrective action forms/quality improvement forms are raised where the results are less than expected however the corrective actions have not been completed and/or signed off as completed. The meeting minutes do not evidence discussion around audit outcomes or improvements. The service completes an annual resident/relative satisfaction survey. The results have not been communicated back to the participants.  The joint owner is responsible for building maintenance and is a health and safety officer who has completed level one and two of health and safety qualifications. Staff complete hazard forms for identified hazards which are reviewed by the health and safety officer. There is a hazard register for each area of work that was last reviewed November 2015.  Falls prevention strategies are in place that includes the reporting of falls and the identification of interventions on a case by case basis to minimise future falls (link 1.2.4.3). |
| 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 Low | As part of the risk management and health and safety framework, there is an accident/incident policy. Five accident/incidents from December 2015 and four accident/incidents from February 2016 were reviewed. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. However, accident/incident forms reviewed had not been fully completed.  The caregivers interviewed could discuss the incident reporting process. The manager collects incidents/accidents monthly to identify and analyse areas of improvement and identify if accidents/incidents could be prevented.  The manager interviewed could describe situations that would require reporting to relevant authorities. There have been no reportable events since the previous audit. |
| 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 to support recruitment practices. The register of RN’s practising certificates and allied health professionals is current. Six staff files were reviewed (one RN, three healthcare assistants (HCAs), one cook and one cleaner). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  Healthcare assistants are supported to commence Careerforce aged care qualifications following appointment and are supported by the manager who is a Careerforce assessor. The manager and RN attend external education at the DHB and have completed interRAI training. A two yearly training calendar includes mandatory education. Infection control and medication are scheduled and have been attended annually. The gerontology nurse specialist provides clinical education. Staff completes competencies relevant to their roles.  Thirteen HCAs work in the dementia care unit and eleven have completed the required dementia unit standards. Two HCAs who have been employed less than one year have one dementia unit standard to complete. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and RN are on duty during the day Monday to Friday and share the on call responsibility. An experienced HCA is the day supervisor who coordinates the team of HCAs on duty.  There are sufficient staff numbers in the rest home and the dementia care unit that meets contractual requirements.  Residents and relatives state there were adequate staff on duty at all times. Staff state they feel supported by the manager and the RN who respond quickly to after-hour calls. |
| 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 residents’ 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 | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.  The service has well-developed information packs available for residents/families at entry for rest home and dementia level of care. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Six admission agreements viewed were signed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. There is a consent form in place and there is safe storage of the medication.  The facility uses a blister pack system. All medication packs have large photo identification. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. In the rest home and dementia unit registered nurses or senior caregivers who have passed their competency, administer medications. Medication competencies are updated annually and staff attends annual education. There are no standing orders. The medication fridge temperatures are not monitored. Eye drops were dated when opened.  Staff sign for the administration of medications on medication sheets held with the medicine charts. Medication administration signing sheets correspond with prescribed medication on the medication chart.  Twelve medication charts were reviewed. All charts were legible, up to date and reviewed at least three monthly by the G.P. Allergy status was recorded on all medication charts. ‘As required’ medications had prescribed indications for use. |
| 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 service employs two cooks. One works Monday to Friday and the other covers the weekends. Both have current food safety certificates. The week day cook oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals are cooked on-site. Meals are served from the kitchen located within the dementia unit and delivered to the rest home on trolleys with insulated covers. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. These all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets were noted in a kitchen folder. The menus have been audited and approved by an external dietitian. Residents and families interviewed were very happy with the meals provided. There was evidence that there are additional nutritious snacks available over 24 hours. |
| 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 records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Risk assessments and long-term care plans reviewed were comprehensively completed for all resident files reviewed. Risk assessments are completed on admission and reviewed six monthly as part of the care plan review. InterRAI assessments were completed for all new admissions. InterRAI assessments are scheduled to be completed for other residents as their care plan evaluations become due in 2016. All interRAI assessments sighted inform the care plans. Additional assessments for management of behaviour and wound care were appropriately completed according to need. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed were comprehensive and evidenced multidisciplinary involvement in the care of the resident. All care plans were resident-centred and documented support needs to achieve the resident/relative goals. Residents and family state they are involved in the care planning process. Long-term care plans for residents in the dementia unit detail care and support for behaviours that challenge, including triggers, associated risks, interventions and management.  Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, geriatrician, gerontology nurse practitioner and mental health services. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | All care plans reviewed included documentation that meets the need of the residents and care plans had been updated as residents` needs changed. When a resident’s condition changes, the RN initiates a GP or nurse specialist consultation. Changes in care are documented on short-term care plans and communicated at handovers as confirmed by HCAs interviewed. There is documented evidence of family notification on the family/whānau communication sheets in resident files reviewed. Family members interviewed confirm they are notified of any changes in their relative’s health status. Family and residents state care delivery and support by staff is consistent with their expectations.  Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessment, wound management and evaluation forms are in place for all wounds. Wound management and monitoring occurred as planned. There are currently four wounds (two minor wounds, one leg ulcer and one skin tear). All have appropriate care documented and provided. Access to specialist advice and support is available as needed.  Monitoring forms are in use as applicable such as weight, observations and wounds. Behaviour charts were in use for any residents that exhibit challenging behaviours. |
| 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 | There is one activities coordinator (42.5 hours weekly) and one activities assistant (12 hours weekly). One has completed dementia training and one is in the process of completing the standards. On the days of audit, residents in all areas were observed being actively involved with a variety of activities. There were daily exercise classes and the dementia unit residents go for a group walk every morning.  There is a weekly programme on display for the rest home residents. The activity programme in the dementia unit programme is flexible and suitable to the residents group or individual needs on the day including frequent one on one activity.  Community visitors include a volunteer who comes in weekly and Lay Catholic personnel for weekly Mass. Other residents are supported to attend their community churches. Bible study sessions are provided on-site for those who wish to attend. There are van outings twice weekly for both groups of residents. There are regular entertainers visiting the home. On the day of audit rest home residents were observed enjoying musical entertainment. Events such as birthdays and special events are celebrated.  Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. The residents' activity care plans have de-escalating techniques for residents with behaviour that might challenge over 24 hours. Activity plans have been completed but not evaluated six monthly (link 1.3.3.4).  The service has introduced an improved activity assessment tool for the use of residents with cognitive impairment. The assessment tool focuses on person-centred care for residents in the dementia care unit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Three out of six care plans reviewed were evaluated by the registered nurses six monthly or when changes to care occurs (link 1.3.3.4). Care plan evaluations link to specific goals. Short-term care plans for short term needs reviewed were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three monthly review by the medical practitioner with residents in the rest home and dementia unit. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where one resident had been referred to mental health services and another to the podiatrist. Discussion with the RN identified that the service has access to a wide range of support either through the GP, specialists and contracted allied health services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are clear policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas in all areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person described the safe management of hazardous material. |
| 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 building holds a current warrant of fitness which expires on 1 June 2016.  Reactive and preventative maintenance occurs. Electrical equipment has been tested and tagged. New chair scales are due to be tested in May. There is a planned maintenance programme in place. Hot water temperatures have been monitored monthly in resident areas and were within the acceptable range.  The living areas, hallways and rest home rooms are carpeted and the dementia rooms have vinyl surfaces as do bathrooms/toilets and kitchen areas. All hallways are wide enough to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is safe access to all communal areas.  The dementia unit is secure from the rest of the facility. There is a large secure external courtyard and garden for the dementia residents. There are quiet, low stimulus areas that provide privacy when required. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate communal toilets and showers in the rest home and dementia unit. One rest home room has an ensuite and all but four rooms have their own toilet and hand basin. In the dementia unit only four rooms have their own toilet and hand basin. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal toilets and bathrooms have appropriate signage and locks on the doors. |
| 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 | Residents' rooms in the rest home and dementia unit are of an adequate size to allow care to be provided and for the safe use of mobility aids. Mobility aids can be managed in ensuite/toilet facilities. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| 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 | Activities occur throughout the facility in the lounge/dining areas. The rest home open plan lounge/dining area is large enough to not impact on other residents who are not involved in activities. Seating and space is arranged to allow both individual and group activities to occur. There is a smaller family lounge where residents who prefer quieter activities or visitors may sit. All communal areas are easily accessed.  In the dementia unit there is adequate space to allow maximum freedom of movement while promoting safety for those that wander. There are two lounge/dining areas which can be used for separate dining and activities (small group or individual). There are spaces for residents who prefer quiet, low stimulus areas. |
| 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 undertaken on-site. The laundry is well organised and is divided into a “dirty” and “clean” area. Staff interviewed state that they manage the workload adequately. There are appropriate systems for managing infectious laundry which laundry staff could describe. There is a comprehensive laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system.(link 1.2.3.6) The cleaners’ equipment was attended at all times or locked away in the sluice rooms as sighted on the day of the audit. There is a sluice room in the rest home and dementia unit for the disposal of soiled water or waste. The sluice rooms and the laundry are kept locked when not in use. |
| 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, adequate food and water and a barbeque for alternative cooking are available.  Six monthly fire evacuations are held. There is an approved fire evacuation plan dated 21 June 1996. The plan is currently being reviewed by the fire service. There have been no building changes. There is a first aider on duty at all times.  Resident’s rooms, communal bathrooms and living areas all have call bells. On the day of audit the call bells had failed. The manager and staff had implemented their emergency system which included the use of whistles to alert staff assistance was required and the additional staff member completed frequent rounds of all residents. The technician responded promptly to address the technical problem.  Security policies and procedures are documented and implemented by staff. The dementia unit is safe and secure with outdoor access to gardens. The buildings are secure with 24 hour intercom access to request entry to the facility. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has plenty of natural light. There are electric panel heaters in all rooms. There are oil heaters in lounge/dining areas which are used for extra warmth in winter. Smoking is only allowed outside in the car port area. Apart from this, the facility and grounds are a smoke-free area. |
| 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 responsibilities for infection control are shared between the manager/RN and the RN. They oversee infection control for the facility. Infection events are collated monthly and reported to management meetings and staff/quality meetings.  There is an infection control programme that has been reviewed annually last in April 2016.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. |
| 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 Infection control coordinators have attended infection control and prevention education provided by the DHB residential aged care programme. The infection control coordinators have access to GPs, local laboratory, the infection control nurse at the local DHB for advice and the gerontology nurse specialist. |
| 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 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 developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and were last reviewed April 2016. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinators are 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. Staff complete hand hygiene competencies annually.  Resident education is expected to occur as part of providing daily cares as appropriate. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinators collate information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports are completed for all infections. Infections are analysed for trends and quality improvements. Graphs and relevant information is communicated to staff and documented in management and staff/quality meetings.  Internal audits for infection control are included in the annual audit schedule (link 1.2.3.6). There is close liaison with the GP that advises and provides 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 minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The manager/RN is the restraint coordinator. On the day of the audit there were no residents on restraints or enablers. Restraint education and challenging behaviours is included in the annual training programme and occurred in May 2015 and March 2016. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Accident/incidents and infections are collected and analysed. Trends and analysis for infection events are discussed and documented in meeting minutes. Internal audits and surveys are completed. Meeting minutes do not document discussion around other quality data. Corrective action forms/quality improvement forms are completed for any areas of improvement resulting from internal audits but these have not been completed/signed off. | (i) Meetings minutes do not evidence discussion around incidents/accidents, infection events, internal audit outcomes and survey results. (ii) Internal audits had been completed with corrective action/quality improvement forms raised for areas of improvement. However, corrective actions had not been followed up and signed off as completed. | (i) Ensure discussions at meetings around quality data and analysis are documented in meeting minutes. (ii) Ensure corrective actions are followed up and signed off as completed.  90 days |
| Criterion 1.2.4.3  The 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 Low | All accidents/incidents have been reported and the cause investigated as applicable. Corrective actions where identified have been documented on the accident/incident form but have not always been followed up and signed off. | Five of nine accident/incident forms reviewed had not been fully completed to evidence documented corrective actions signed off as completed. | Ensure corrective actions identified are signed off as completed.  60 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The facility uses a blister pack system. All medication packs have large photo identification. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are stored safely. There were no expired medications on the day of audit. There was no record of fridge temperatures taken and recorded. | Temperatures were not being recorded for the medication fridge as per the MOH medication guidelines. | Ensure medication fridge temperatures are taken and recorded regularly  30 days |
| Criterion 1.3.3.3  Each 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 Low | Six resident files were reviewed (three rest homes and three dementia). All six long-term care plans identified that the registered nurse has undertaken an initial assessment and had developed comprehensive long-term care plans within the required timeframes.  Residents/family confirmed on interview that they are involved in the care planning process and review. Three of six long-term care plans had been evaluated six monthly or more often as needed. Two residents (one rest home and one dementia) had not been at the service six months and one care plan (dementia care) had not been evaluated six monthly. | 1) One long-term care plan (dementia care) has not been evaluated six monthly.  2) One short-term care plan (rest home) that has been evaluated does not have the ongoing problem transferred to the long-term care plan.  3) Activities plans (three rest home and three dementia care) have not been evaluated six monthly | Ensure long-term care plans are evaluated six monthly.  Ensure ongoing problems from short-term care plans are transferred to long-term care plans.  Ensure activities plans are evaluated six monthly.  90 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.