# Coronation Lodge 2006 Limited - Coronation Lodge 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 Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Coronation Lodge 2006 Limited

**Premises audited:** Coronation Lodge Rest Home

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

**Dates of audit:** Start date: 24 May 2016 End date: 24 May 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 19

# 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

Coronation Lodge provides residential care for up to 20 residents who require rest home level care. The facility is operated by Coronation Lodge 2006 Limited.

This certification audit was conducted against the Health and Disability Service Standards and the provider’s contract with the District Health Board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

There are no areas requiring improvement.

## 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. |

Services are provided that respect the personal privacy, independence, individual needs and dignity of residents. Staff receive regular education on residents’ rights and how to implement these. During the audit staff were noted to be interacting with residents in a respectful manner.

Well-established processes are in place to promote open communication, and residents and their families confirmed these were effective.

Policies are well understood by staff who ensure residents are free from discrimination or abuse/neglect.

The facility manager is responsible for the management of complaints. A complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Coronation Lodge 2006 Limited is the governing body and is responsible for the service provided. There is a current business plan. Quality and risk management systems are fully implemented at Coronation Lodge.

The facility manager is an owner/operator/director of the company which has owned and operated Coronation Lodge since 2006. The facility manager has aged care and management experience and is supported by an experienced registered nurse. The registered nurse is responsible for oversight of clinical care provided to residents.

There is an internal audit programme. Risks are identified. Adverse events are documented on accident/incident forms. Corrective action plans are being developed, implemented, monitored and signed off. Combined quality and staff meetings are held and there is reporting of clinical indicators, quality and risk issues and discussion of any trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management and human resource processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and attendance sheets are held on file. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and registered nurse are rostered on call after hours. Staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported satisfaction with the number of staff on duty to provide care.

Resident information is current, accurately recorded and maintained in a secure and confidential manner.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Care plans are developed in a timely manner by the registered nurse. Plans are individualised and comprehensive. Residents’ care is evaluated on a regular basis, and more frequently when residents’ needs change.

There are well-established processes in place to guide continuity of care, such as the updating of resident progress notes each shift and written and verbal handover of information between shifts. The registered nurse and the facility manager are accessible at all times if assistance is required.

A diversional therapist manages the residents’ activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community and a facility van is available for resident outings. Resident meetings are held monthly.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

All aspects of medication meet legislative and best practice requirements. Medications are administered by staff that are competent.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

All bedrooms provide single accommodation and have wash hand basins. Residents' rooms have adequate personal space provided. Lounges, a dining area and alcoves are available. External areas are available for sitting and shading is provided.

There is a call bell system and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems are monitored to evaluate the effectiveness of these services.

## Restraint minimisation and safe practice

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

The service has documented policies and procedures for restraint minimisation and safe practice. Systems are in place that ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary and the least restrictive option.

There are residents using restraint. Staff education includes all required aspects of restraint and enabler use along with alternatives to restraint and behavioural management. Staff verified knowledge and understanding of all restraint and enabler processes.

## Infection prevention and control

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

Infection prevention and control is well managed by the service. The infection control nurse has received relevant training and is supported in the role by the facility manager. There is regular infection control training for staff, which has access to an appropriate range of personal protective equipment.

Infection surveillance is managed comprehensively. The results of the monthly infection surveillance reports are reported to management and staff.

## 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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The orientation of all new staff includes education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code), and education is then provided on the Code annually. This was confirmed in staff education records and in interviews with staff. Staff demonstrated a good understanding of the Code and how this is implemented into their everyday practice.  |
| 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 | There is an informed consent policy to guide service providers. At the time of admission, residents or their EPOA sign a general consent form covering various areas. Consent is then reviewed annually and as required.There were resident’s records that evidenced a completed resuscitation authorisation form and some with advance directives. Residents confirmed they were routinely offered the opportunity to make informed choices and that their consent was obtained and respected. Family members also confirmed their involvement in consent process when appropriate, and of being kept informed about what was happening with the resident. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | New residents and their families are provided with an information package which includes a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure. Residents and family members confirmed their awareness of the Advocacy Service and how to access it. Information on the Advocacy Service is also readily accessible around the facility. The staff orientation programme includes information on the Advocacy Service with ongoing education provided for staff. Staff have received education on advocacy as confirmed in staff education records. Staff demonstrated their understanding of the Advocacy Service and how this service could be contacted.  |
| 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 | Residents’ family and friends are encouraged to visit and there are no restrictions on when they can visit. All family members stated they felt welcomed when they visited. Residents are encouraged to independently engage with the community, such as going out with family and friends, attending health professional appointments and shopping. The facility manager advised residents are also supported to participate in community events, with regular outings. Visiting entertainers, and church services are also 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 facility manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There is evidence that complaints are managed appropriately.Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Staff meeting minutes evidenced reporting of complaints to staff. Staff confirmed this information is reported to them via staff meetings.There have been no investigations by the Health and Disability Commissioner (HDC), Ministry of Health, the DHB, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | As part of the admission process new residents and their family are provided with a copy of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service). Discussions and explanations are provided as required by the individual resident and/or their family. Copies of the Code, and the information on the Advocacy Service are also displayed around the facility.Residents and family members confirmed their understanding of residents’ rights and that information had been provided on the Code and the Advocacy Service.  |
| 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 | All residents have a private room. Resident’s privacy was maintained at all times.Staff interactions with residents were observed to be respectful and pleasant, and included the use of the resident’s preferred name. Staff encourage residents to maintain their independence.Residents’ records confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their lifestyle plan. Plans were developed in partnership with the resident and/or their family. Residents and families stated they are treated respectfully and their individual needs are met.The privacy of residents’ information was maintained. Clinical files are kept in a locked cabinet. Archived records were stored securely. Staff demonstrated a good understanding of the service’s policy on abuse and neglect. They provided examples of what could constitute abuse and neglect and the actions they would take if they suspected this. Abuse and neglect education is part of the orientation process for staff, and is then provided on an annual basis, as confirmed in staff and education records.  |
| 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 are well developed policies to ensure appropriate services are provided to residents who identify as Maori. Cultural beliefs and related requirements are integrated throughout each resident’s care plan. The facility manager provided details of organisations and the advisor who could be contacted if additional cultural support was required for any resident. There are currently no residents who identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The personal values, beliefs and cultural requirements were documented in all care plans reviewed. There was evidence of resident/family involvement in the development of these plans. The family members confirmed they had been consulted about individual values, beliefs and cultural requirements at the time of admission and as part of the care plan review process. They also confirmed that these values and beliefs were respected. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | All residents and family members stated that residents were free from any type of discrimination or exploitation. The general practitioner who visits regularly also confirmed satisfaction with the services provided to residents, and confidence that residents are free from any form of discrimination, abuse or exploitation.Staff receive education about discrimination and exploitation as part of the orientation process, with ongoing education provided, as confirmed in staff interviews and education records. Staff gave examples of what would constitute inappropriate behaviour, and the actions they should take if they suspected this was occurring. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | There is a range of current clinical policies available to guide care delivery. Residents’ records evidenced input from health providers. The registered nurse advised that these specialist providers were available as resources if additional expertise was required. The general practitioner stated they were satisfied with standard of care provided.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incident forms, resident communication sheets and timeframes for when family members wish to be contacted confirmed open communication with residents and/or their families. There was also evidence of resident/family input into the care planning process. Family members stated they were informed in a timely manner about any changes to the resident’s condition and felt fully involved in all aspects of care planning and evaluation. The facility manager advised that interpreter services were able to be accessed via the Local DHB or information centre if required. The facility manager advised they have not had to use interpreter services in the past. Residents’ monthly meeting minutes evidenced further opportunity for communication with residents. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Coronation Lodge 2006 Limited is the governing body and is responsible for the services provided at Coronation Lodge. The current business plan has a philosophy that reflects a resident and family centred approach, a mission statement, goals and objectives. The facility manager is an owner/operator/director of the company which has owned and operated Coronation Lodge since 2006. There is a current organisation chart that clearly shows lines of responsibility and delegations of authority.The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.The facility manager is an experienced and suitably qualified manager who is also a diversional therapist. The facility manager is supported by an experienced registered nurse. The registered nurse is responsible for oversight of the clinical service in the facility.Coronation Lodge is certified to provide rest home level services. On the day of this audit there were 19 rest home residents.Coronation Lodge has contracts with the District Health Board (DHB) to provide ‘Aged Related Residential Care’, ‘Residential Respite Services’, and ‘Short Term Residential Care Services’.Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This information is included in the service agreement and admission agreements. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the absence of the facility manager, the registered nurse deputises. When the registered nurse is absent, a casual registered nurse takes responsibility for clinical oversight. The facility manager and the registered nurse confirmed their responsibility and authority for these roles. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk plan guides the quality programme and includes goals and objectives. There was evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. Corrective action plans are being developed, implemented and reviewed. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. A resident/family satisfaction survey was completed for 2015 and results indicated that residents and families are satisfied or very satisfied with the services provided. Combined quality and staff meetings are held monthly. Meeting minutes evidenced reporting of various clinical indicators and quality and risk issues. Staff reported that copies of meeting minutes and graphs of clinical indicators are available for them to review in the staff area. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies and procedures are reviewed by management and are current. Staff confirmed that they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery. Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents. The facility manager is responsible for hazards and demonstrated good knowledge. Hazards and safety issues are discussed at the monthly quality and staff meetings. Meeting minutes confirmed this. Staff confirmed they understood and implemented documented hazard identification processes. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Adverse, unplanned or untoward events are documented by staff. Collated data is analysed by the facility manager. Data includes summaries and registers of clinical indicators. Documentation reviewed and interviews of staff evidenced appropriate management of adverse events. There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events or any change in the resident’s condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The facility manager confirmed there has been one essential notification to the Ministry of Health since the last audit and documentation confirmed this. Staff confirmed they are aware of reporting requirements. |
| 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 management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, references, employment agreements, completed orientation, competency assessments and police vetting.The facility manager and registered nurse are responsible for managing the in-service education programme. In-service education is provided for staff at least monthly as part of the staff meetings. There is also a study day during the first half of the year that provides a variety of topics. This is repeated in the second half of the year so that all staff receive this education. Individual records of education are maintained as are competency assessments. Care staff are encouraged to complete a New Zealand Qualifications Authority education programme. There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided. Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at ongoing in-service education and currency of their performance appraisals. The registered nurse has completed the interRAI assessment programme 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 | There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. The minimum number of staff is provided during the night shift and consists of one caregiver. The facility manager and the registered nurse are rostered on-call after hours. The facility manager resides across the road from the facility. Staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family reported there was enough staff on duty that provided them or their relative with safe appropriate care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Residents’ records evidenced the resident’s unique identifier. Clinical records were well-organised and integrated and included current interRAI assessment reports. Resident files are kept in a locked cabinet when not being used. The names of people making entries into the records was legible and their designation clear. Caregivers document the care provided to residents in the progress notes each shift.  |
| 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 | When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. The registered nurse outlined the processes associated with service entry. Prospective residents are provided with detailed information about the service and they are also advised they can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination Service.Family members and residents’ interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes. All residents’ clinical record folders reviewed contained a transfer form ready for completion for emergency transfer situations.  |
| 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 | All aspects of medication management are consistent with legislative requirements and safe practice guidelines, as evidenced by documentation, observation and interview. A safe system for medicine management is observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administer medicines are competent to perform the function they manage. Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart. Resident allergy status was documented, and medication administration records were complete.The registered nurse advised that medications are checked against the medication chart by a RN on arrival to the service, and this is evidenced. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. Surplus and expired medication are returned to the pharmacy. Residents’ who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis and management of any medication errors, and compliance with this process is verified. Standing orders are used. Documentation is specific to each individual resident and compliant with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietician’s documented July-2015 assessment of the planned menu. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is sighted. There is an effective and systematic approach to ensuring that residents’ nutrition and fluid intake is carefully monitored monthly and followed up when a concern arises. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification by the person responsible that this has been attended to.Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| 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 | An interview with the registered nurse verified a process exists for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely format that was understood. Assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | As verified by observation, interviews and documentation, when admitted residents have their needs identified through a variety of information sources. This includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present if requested. Over the following three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. All resident records reviewed contained a current interRAI assessment in addition to other clinical assessments as indicated. A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Files reviewed evidence all residents have an individualised care plan. The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident requires from care staff, to meet their goals and desired outcomes. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned. Care plans are evaluated six monthly or more frequently as the resident's condition dictates. Residents and families interviewed confirmed their participation in the development of care plans and their ongoing evaluation and review. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents’ needs and desired outcomes. The facility manager and the registered nurse are on call 24 hours a day to provide support and guidance for care delivery staff and well-established processes are in place to ensure continuity of care. An interview with the GP confirmed satisfaction with the standard of care provided to residents.Residents and family/whanau members expressed satisfaction with the care provided. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The facility manager is a registered diversional therapist (DT) and coordinates the residents’ activity programme, supported by a second staff member. The DT advised that residents are assessed on admission to ascertain their previous and current interests, needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data.The residents’ individualised activity plan is reviewed as part of the care plan.Documentation, observation and interviews verify activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. A residents’ meeting is held monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and there is satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurse (RN) is responsible for the evaluation of resident progress towards previously identified goals. Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN. Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occur every six months or as residents’ needs change. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the District Health Board (DHB). Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Support is available to transport and accompany residents to health-related visits outside of the facility, such as hospital appointments or visits to the dentist, if there is no family member available to accompany them.Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| 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 documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The hazard register is current. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff. There is protective clothing and equipment appropriate to recognised risks. There was protective clothing and equipment sighted in the sluice room and being used by staff. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness was displayed. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. All residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The facility manager and observation confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.There are external areas available that are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.Staff confirmed they have access to appropriate equipment and they are competent to use it.Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned.  |
| 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 | All bedrooms have a wash hand basin. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access. There are appropriate locking facilities and engaged / not engaged notices.Appropriately secured and approved handrails are provided and other equipment is available to promote resident’s independence. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All bedrooms provide single accommodation. There is adequate personal space provided for residents and staff to move around safely within the bedrooms. Residents spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments. There is room to store mobility aids such as mobility scooters and wheel chairs. |
| 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 are several areas for residents to frequent for activities, dining, relaxing and for privacy. These areas are easily accessed by residents and staff. Residents confirmed this. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. |
| 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 washed on site. Residents and family reported the laundry is managed well and resident’s clothes are returned in a timely manner. Care staff are responsible for the laundry service.There is a dedicated cleaner who has received appropriate education. Interview of the cleaner and education records confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation scheme. There is an evacuation policy on emergency and security situations and covers the service group at the facility. A fire drill takes place six-monthly and documentation sent to the New Zealand Fire Service. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures.There is always at least one staff member on duty with a current first aid certificate.All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.There is a civil defence plan in place. There are adequate supplies in the event of a civil defence emergency.There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.Contractors must sign in and out of the facility. They are also made aware of any hazards on site. The facility is made secure at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by gas heaters. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The service has an infection prevention and control programme that is reviewed annually (March-2016) to maintain and monitor and establish new procedures covering infection control practices. The practices are guided by the infection control manual, with assistance from an external infection control advisor and the DHB infection control nurse. It is the responsibility of all staff to adhere to the procedures and guidelines when carrying out all work practices.The registered nurse is the designated infection control nurse. Infection control matters, including surveillance results, are reported monthly at the quality/staff meetings and to the facility manager. Meeting minutes and monthly reports were sighted. A sign at the main entrance to the facility asks anyone who is or has been unwell not to enter the facility, and reminds visitors about the need for hand washing. Information for staff on how long they must stay away from work if they have been unwell is included in the infection control manual and provides guidance for staff.  |
| 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 infection control nurse (ICN) is responsible for implementing the infection control programme and reports directly to the facility manager. A position description is included in the infection control (IC) programme. The infection control nurse has attended infection control management training courses, as confirmed in training records. If required, advice is able to be sought from a range of sources that include an infection control manual produced by an external provider; the infection control nurse at the District Health Board, the Public Health unit, online resources and articles |
| 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 | An infection control policy and procedure manual guides infection prevention and control practices. These comply with relevant legislation and current accepted good practice. The manual is reviewed annually, with the last review being undertaken in March-2016. Housekeeping and kitchen staff were observed to be compliant with infection control practices. Care delivery staff were observed using hand-sanitizers on a regular basis and wearing disposable aprons and gloves as appropriate. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and annual ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectations. Resident education occurs in a manner that recognises and meets the residents’ and the families’ communication style. Education with residents is generally on a one-to-one basis. This may include reminders about hand washing or the need for an increased fluid intake in warmer weather. |
| 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 | Surveillance of infections (respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections) is the responsibility of the Infection control nurse.Incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Monthly surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions. Meeting minutes and interviews verify data is presented to the facility manager and quality/staff meetings and any ongoing corrective actions discussed and implemented. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The service aims to minimise the use of restraint and to ensure that restraint or enabler practice occurs in a respectful manner and is the least restrictive option to meet the needs of the resident.Environmental restraint is practiced at this facility, with keypad access and a door alarm system which is activated at all times. Staff, visitors and residents for whom restraint is not intended do not have freedom of movement restricted as they are able to exit the facility by entering a specified code displayed above the keypad. In event of a fire, the activation of the fire alarm unlocks the doors. There are clear organisational responsibilities and clinical justification for the use of restraint with provisions to ensure residents are reassessed when clinically indicated through an external assessment process, to determine the most appropriate level of care is provided. Evidence verifies restraint is used appropriately. Five residents currently require some form of restraint. There are no residents requiring the use of enablers. Care plans included use of alternative interventions to restraint, and all residents’ are able to freely mobilise within the facility. The restraint register identifies all residents using restraint, when restraints are commenced and when they are stopped if no longer required.The restraint coordinator who is the RN reported a review of all restraint is conducted monthly. In-service education relating to restraint and challenging behaviour has been provided. Restraint usage is an agenda item for the quality/staff meetings. Care staff demonstrated good knowledge of restraint and enabler processes. Residents’ files evidenced completed documentation relating to restraint use. |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | Policy identifies the responsibility for the restraint process and approval. This was understood by all clinical staff interviewed and annual education related to restraint is a mandatory topic. Staff education includes safe restraint use and challenging behaviour management. The policy states that the cultural, clinical and safety needs of the resident must be met when dealing with challenging behaviour.Documentation is completed for restraint approval and identifies resident and family/whānau input. Two residents’ files were reviewed to look specifically at restraint. All paper work was fully completed and the use of restraint is shown on the care plan. The restraint coordinator (RN) leads the restraint approval process. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The assessment undertaken prior to restraint use being approved covers all risk factors to meet the requirements of the safe practice. Assessments are undertaken by a RN and include the facility manager, GP, family/whānau and the resident where appropriate, prior to approval. This process is well documented.The residents' files reviewed evidenced restraint assessment risks were documented and evaluated on a regular basis and included resident and/or family input. The multidisciplinary reviews evidenced restraint assessment risks were reviewed. Clinical staff interviewed demonstrated a sound knowledge concerning restraint procedures |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Prior to restraint being used, alternative safety methods are trialled. This includes the use of low beds and correct positioning. With the exception of environmental restraint, the only restraints used by the service are bedside rails and chair lap belts to prevent falls. Once restraint is approved it is documented in the restraint register which establishes a record with sufficient information to provide ongoing auditing of restraint use. The restraint policies and procedures identified risk processes that are to be followed when a resident is being restrained. The residents' files evidenced details of initiating restraint, monitoring while on restraint, evaluations, review of restraint goals and interventions and were current. The restraint consents by resident and/or family were current. The restraint register was current and provides sufficient information. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The residents' files evidenced each episode of restraint was monitored and evaluated based on the risk of the restraint used. The resident’s care plan evaluations and multidisciplinary meetings were current. Residents requiring restraint are reviewed at monthly quality/staff meetings. The RN is responsible for evaluating restraint use and this was verified by documentation and interview. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint reviews were completed at least three monthly. The outcome of the reviews were documented and reported on, as well as being discussed at meetings. Policies and procedures included monitoring and quality review processes. The last restraint audit acknowledged compliance with policy. Staff education is also monitored as part of the quality review. |

# Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |

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

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

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

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

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End of the report.