

Sandra MacLean - Lady Elizabeth Home and Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Sandra MacLean
Premises audited:	Lady Elizabeth Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 June 2016 End date: 10 June 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:	54

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

Indicator	Description	Definition
	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

Lady Elizabeth Home and Hospital is privately owned. It provides care for up to 55 residents. There are seven rest home level care beds, 28 hospital level care beds and 20 beds which are dual purpose and can be used for either rest home or hospital.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

There are no areas identified for improvement from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A copy of the Code brochure is available at reception. Families interviewed reported that staff work in a caring manner and respect each resident.


There are no residents who identified as Maori residing at the service at the time of audit.

Written consents are obtained from the resident, resident's family/whanau, enduring power of attorney (EPOA) or appointed guardian, as required. Signed consent forms were sighted in all residents' files reviewed.

The organisation provides services that reflect current accepted good practice and this was evident in the residents' progress notes reviewed.

The organisation respects and supports the right of the resident to make a complaint. There have been no complaints made since the previous audit.

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.
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The service undertakes business and strategic planning to ensure all aspects of service delivery are reviewed and services are provided to meet residents' needs. There are documented quality and risk processes implemented by the service to support effective and timely service delivery. Corrective action planning is implemented to manage any areas of concern or deficits.


The owner/manager/registered nurse (manager) is responsible for the overall management of the facility.

The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among staff, residents and families/whānau, as appropriate.

The service employs an appropriate number of staff with the right skill mix to ensure contractual requirements are met. Human resources management processes identify good practice and meet legislative requirements.

There are appropriate information systems which accurately record current and confidential information. Noncurrent files are filed in storage and available when required.

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.
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Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

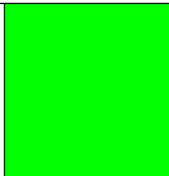
Residents have an initial nursing assessment and care plan developed by the registered nurses (RN) on admission to the service. The service meets the contractual time frames for the development of the long term care plan. When there are changes in a resident's needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly using the interRAI assessment tools. Residents are reviewed by a GP on admission to the service and at least three monthly. The families interviewed reported that care plans are implemented and that the service manages the residents in a manner that is professional and caring.

The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit. Staff responsible for medicine management have been assessed as competent.

Residents' nutritional requirements are met by the service with likes, dislikes and special diets catered for and food available 24 hours a day. The service has a four-week summer/winter rotating menu which has been approved by a dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. Medical and electrical equipment is checked to meet legislative requirements.

Documentation sighted and interviews with residents and families/whānau identify that the facilities meet residents' needs with the provision of appropriate furnishings, single bedrooms, adequate toilet, bathing, hand-washing, and dining and relaxation areas. The service has a long term maintenance plan and ongoing reactive maintenance is undertaken by contracted services.

The facility is appropriately heated and ventilated. The outdoor areas provide suitable furnishings and shade for residents' use.

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.
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Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety.

At the time of audit there is one restraint which is a bedside rail. Restraint approval and assessment processes have been undertaken to meet the requirements of this standard. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints. Restraint is used for safety reasons only.

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.
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The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to residents, staff and visitors. The surveillance programme is appropriate for the size and nature of the services provided. Monthly surveillance data and audits are recorded, collated and reported to management. The Infection Prevention and Control Coordinator is suitably qualified for the role and implements and reviews the infection control programme annually.

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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme, which was sighted. Residents' rights are upheld by staff (e.g., staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>Residents are provided with information on the Code on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the RN. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (e.g., with the resident in their room).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted on the form. Information is provided on enduring power of attorney (EPOA) and</p>

<p>need to make informed choices and give informed consent.</p>		<p>ensuring where applicable this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. The RNs discuss information on informed consent with the resident and family on admission. The files reviewed had signed advance directive forms which meet legislative requirements.</p> <p>Family members and residents are actively involved and included in care decisions as evidenced in residents' files reviewed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons. This was confirmed in interview with residents and family. The advocacy brochure is available in other languages.</p> <p>Education is undertaken annually as part of the in-service education programme relating to advocacy and services available. The staff interviewed report knowledge of residents' rights and advocacy service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents reported on interview that they are supported to be able to remain in contact with the community by going on outings and the walks to local shops and parks. Policy includes procedures to be undertaken to assist residents to access community services should they request this.</p> <p>There is a portable phone which is taken to the residents as needed to support communication with family and friends.</p> <p>Evidence in files reviewed showed attendance at DHB for appointments as required.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service implements documented complaints management policy and procedures as confirmed by the manager. Complaints are recorded in a register which identifies that no complaints have been received since the previous audit. Complaints processes which reflect a fair complaints system are discussed with residents and family/whānau as part of the admission process. Complaints forms are available in the main foyer and/or from the nurses' station. Residents, family/whānau and staff reported during interview that they understand the complaints processes in place and are aware of where to find written complaints forms.</p> <p>Complaints are a standing agenda item for staff meetings as confirmed in meeting minutes sighted.</p>

		There were no outstanding complaints at the time of audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Staff are provided with training on the Code and residents are provided with information on entry to the service. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (e.g., with the resident in their room). There is information regarding the code available at reception and posters around the facility.</p> <p>Residents are addressed in a respectful manner as was confirmed in interview with residents and families.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff ensure privacy by knocking on doors before entering and closing on exit if requested. The process for accessing personal health information is detailed in the related policy.</p> <p>Evidence was seen in files reviewed of the residents' goals which are personalised and reviewed every six months.</p> <p>Staff interviewed report knowledge of residents' rights and understand the principles of dignity and respect.</p> <p>Residents reported on interview that they are treated with patience and encouraged to be as independent as possible.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The relevant policy reviewed included a range of cultural issues/considerations for staff to be aware of and a commitment to the Treaty of Waitangi. Family/next of kin input and involvement in service delivery/decision making is sought if applicable.</p> <p>There were no Maori residents in the service at the time of audit. Education was given to staff on the Treaty of Waitangi and staff interviewed reported that they understand the principles of the Treaty. Staff verbalised on interview their knowledge of the Treaty of Waitangi and respect for different cultures.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>The RN assesses the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health needs and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as requested</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>by the resident.</p> <p>If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided as confirmed in interviews with residents.</p> <p>Staff interviewed reported on the need to respect the individual's culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment position descriptions and the Code of Rights define residents' rights relating to discrimination. There was no evidence of any behaviour that required reporting and interviews with residents indicated no concerns.</p> <p>Staff reported on interview knowledge of residents' rights and their understanding of elder abuse of any type.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence was seen of care staff undertaking or having completed the National Certificate in the Care of the Elderly Education programme. All staff have an up to date first aid certificates and all staff who administer medication have yearly assessments to determine competency.</p> <p>The RNs attend education sessions run by the DHB and other local organisations. The planned yearly education programme reviewed included sessions that ensures an environment of good practice. The food service cooks have fulfilled the requirements of safe food handling. Residents' reported on interview satisfaction with the meals and care and that any concerns are listened to at monthly meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The service promotes an environment that optimises communication and provides staff education related to appropriate communication methods.</p> <p>Family interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in the residents' files reviewed, on the accident/incident form and in the residents' progress notes.</p>

		The cultural appropriate document says that residents and families who do not speak English shall be advised of the availability of an interpreter at the first point of contact with the service.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The organisation's philosophy, mission statement and values are clearly documented. Lady Elizabeth Home and Hospital has a strategic plan in place which has been reviewed for the 2016 year. The review identifies any known issues and this information is used in forward planning where relevant. Goals and objectives are set for the coming year and they inform the quality plan. The quality plan sighted describes how the organisation's goals are monitored and evaluated by the manager to ensure residents' needs are being met. Monthly reporting of quality data is reviewed at staff and RN meetings and outcomes are measured against set goals.</p> <p>On the days of audit there were 54 beds occupied consisting of 25 rest home and 29 hospital level residents.</p> <p>The sole manager/owner, who is a registered nurse with a current practising certificate, has been in the role for over 30 years. The manager maintains ongoing education related to the role undertaken both clinically and managerial. They oversee all aspects of service delivery and they are supported by a team of registered nurses.</p> <p>Interviews with residents and family/whānau confirmed that they are very happy with the services provided and that they can contact the manager at any time. Positive management interaction with residents, family/whanau and staff was observed on the days of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>The manager provides succession planning with senior RNs who undertake the management role with assistance from the administrator who has worked at the facility for over 20 years when required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	FA	<p>The service has a quality and risk management system which was understood and implemented by service providers. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>place to address the situation. Information is shared at staff meetings as confirmed in meeting minutes sighted. Policies not reviewed prior to the audit have now all been sighted and are up to date.</p> <p>Quality data collected is analysed, evaluated and trended against previously collected data. Information is used to inform annual objectives to ensure services meet resident needs. The service has an active falls prevention programme in place and all data from falls are analysed to identify any common trends such as time of day.</p> <p>Actual and potential risks are identified and documented in the hazard register showing how the risks are managed. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. Actions taken are identified in the health and safety meeting minutes. (The health and safety meetings also covers infection control).</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management. One example related to the foot plate on a wheelchair and this has been resolved.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>Adverse event reporting as identified in policy is implemented by the service. The manager confirmed their awareness of the requirement related to statutory and or/regulatory reporting obligations including pressure injury reporting. This is confirmed in a section 31 report sighted for a pressure injury which is now healed.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Incident and accident forms were reviewed for 2016.</p> <p>Interviews and documentation sighted confirmed family/whānau are notified of any adverse events or concerns staff have about residents.</p> <p>The manager confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. The staff files reviewed contained job descriptions, completed orientation records, competencies related to the roles performed, staff education, reference checks and police checks. There is a process in place to show that staff who require annual practising certificates have them validated upon commencement of employment and yearly</p>

<p>practice and meet the requirements of legislation.</p>		<p>thereafter. Some competencies are repeated annually such as medication management.</p> <p>There are individual staff education attendance records covering both on-site and off-site training and education attended. Staff are encouraged to maintain a portfolio of education and all RNs had a portfolio to show how professional qualifications are maintained. Some caregivers also had a portfolio of education. The education calendar sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education relates to age care and health care services. Three RNs are interRAI trained and all staff maintain a current first aid certificate. The manager is an aged care education assessor and caregivers are encouraged to complete recognised aged care qualifications. The manager holds an education night once a week which is open all staff but is primarily aimed at newer staff members which covers topics such as the management of difficult behaviour, communication, ethics, residents' rights and basic nursing care.</p> <p>Resident and family/whānau members interviewed confirmed that services are delivered in a professional manner and that their needs are met by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a staff planning document which identifies that the manager is responsible for rostering staff with skills and knowledge to ensure all residents' needs are met. The rosters sighted show that staff levels exceed contractual requirements for all shifts. There are six private dwellings on the same site as the care facility and there is always extra staff rostered across all shifts in case someone from these dwellings seeks assistance. Staff stated that if the workload increases owing to a resident who may require extra care (eg, palliative care), additional staff are always rostered.</p> <p>A review of three weeks rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>The activities coordinator works Monday to Friday and there are dedicated kitchen, laundry and cleaning staff seven days a week. The manager who lives on site is on call when required. All shifts are covered by a RN.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and to track records. This includes information gathered at the time of admission to the service, with the involvement of family. There is sufficient detail in residents' files to identify residents' ongoing care history and activities.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the</p>

<p>when required.</p>		<p>procedures for maintaining confidentiality of residents' records. Residents' files are protected from unauthorised access by being locked in a filing cabinet in a locked room. Staff files are secured in a key access filing cabinet and the manager's office is locked when not in use.</p> <p>Entries are legible, dated and signed by the relevant staff member or allied health professional, including designation.</p> <p>Individual resident's files demonstrated service integration, including medical care interventions. Medication records are in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Entry into the service is undertaken by the manager who is a RN. She undertakes a tour of the facility and ensures the prospective resident is suitable for the services supplied at the facility. Suitable information brochures are available and contain all relevant information.</p> <p>Referrals are usually through the Needs Assessment and Service Coordination (NASC) assessment team and from the surrounding community. The NASC team are aware of the level of care available at this facility.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a specific transfer form to document information involving the resident being transferred to the DHB. The form highlights any known risks, such as falls, includes current medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate.</p> <p>When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current treatments and observations. A verbal handover is given by the RN on duty. Communication is maintained with the family as confirmed on interview.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication records reviewed were dated, signed off and signatures can be verified with the specimen signature list. Photo-identification was seen on each record sighted. Allergies and sensitivity are documented on signing sheets. There is evidence that signing sheets are recorded appropriately and alert stickers are available. Signature specimen lists are in the front of each medication folder for the medical and nursing staff for verification if required.</p> <p>There were no residents self-medicating at the time of the audit and there are no standing orders at this facility. The staff responsible for medication management have all completed medication</p>

		<p>competencies and on-going education relating to medication management as verified on the education record spreadsheet reviewed.</p> <p>The service implements reconciliation processes which include the checking of all blister packs for accuracy by the RN when delivered to the facility and all medication charts are faxed to the pharmacy and checked against the medical review updates every three months.</p> <p>The GP conducts medicine reconciliation when residents are admitted to the service and at least three monthly thereafter. Medicine file reviews showed that each medication is individually signed.</p> <p>Relevant processes relating to controlled drugs meet legislative requirements.</p> <p>There have been no reports of medication errors over the last year. A quality process is available should this be required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food monitoring of all the fridges and freezers occurs on a daily basis and the records reviewed showed that temperatures are within the required range. All equipment and resources are readily available, inclusive of personal protective items, such as gloves, hats and aprons. The kitchen has designated areas for food preparation, plating/tray system serving areas, clean and dirty areas as required. The kitchen was very clean on the days of audit. Daily cleaning schedules are met by the staff in all areas of the food service, as was observed. Rubbish was stored appropriately and disposal processes are in place. A waste management protocol is followed.</p> <p>When a resident is admitted a nutritional assessment is performed by the RN and the information is given to the cook. Any special dietary requirements or special diets are recorded and acknowledged by the kitchen staff when preparing the individual meals. Birthday cakes are made when residents celebrate this occasion.</p> <p>Evidence of menu reviews being undertaken by a registered dietary service contracted to provide advice and support were noted. Changes suggested by the dietitian are implemented as part of the quality programme. Staffing in the food service is consistent over seven days and evidence was seen of safe food handling certificates for staff who work in the area.</p> <p>Residents reported satisfaction with the meals and this is supported in satisfaction surveys. Alternative meals are offered on request.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>The manager reported that the needs assessment team at the DHB usually ring and a telephone discussion verifies the suitability for admission before the family visits, if the resident is in hospital. As the facility has a waiting list for an available bed this is discussed with prospective residents/families</p>

<p>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.</p>		<p>at the time. Their name is put on the waiting list and the family is informed. If the resident settles elsewhere there is no obligation to transfer when a bed is available.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial nursing assessment includes good use of clinical tools, including falls risk, pressure injury risk and pain assessment. Referral letters are sighted from external agencies, including DHB clinics, and there is evidence of family involvement in the assessment process. Evidence was sighted in files reviewed that assessments are conducted within the specified timeframes. The interRAI assessment information is used as part of care plan development.</p> <p>The RNs reported that they oversee all care plans and residents and family are included. Residents reported on interview they were involved in the assessment process on admission.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>In all files reviewed evidence was sighted of interventions related to the desired outcomes of each resident. Risks identified on admission were included in the care plan and these included falls risk, pressure injury risk and pain management.</p> <p>All health professionals document in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to care plans at shift changeover. The care plan is written in a language that is user friendly and able to be understood by all staff.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>There is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated as required and within timeframes to ensure residents' planned outcomes are being met. There is evidence in documentation reviewed of a resident whose falls risk assessment had changed from a low to medium risk. Changes to the care plans included regular checking of the resident and leaving the call bell accessible.</p> <p>The care staff interviewed reported they were informed of any care plan changes at hand over and have relevant in-service education as required specific to any new interventions.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>There is an activity coordinator who is responsible for implementing the activity programme. A qualified diversional therapist (DT) is contracted to the facility who oversees the programme and supports the activity coordinator. The DT oversees visits monthly to meet with staff and review paperwork. She was not available for interview during the time of the audit.</p> <p>Evidence was seen of monthly resident meetings, resident satisfaction surveys and follow up on all concerns and suggestions.</p> <p>Evidence was seen on the programme of music, walks, animal visits and school visits. A church service is available for all residents in the chapel and puzzles, bingo and bowls are all popular.</p> <p>Staff interviewed ensure that an activity is undertaken when regular activity staff are not available. Ongoing education is undertaken by the DT and caregivers reported on interview they enjoy doing games with the residents as required.</p> <p>Residents and family interviewed reported they are happy with the activities and entertainment available.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Reviews and ongoing assessments of residents are clearly documented in the residents' files reviewed. The medical consultations were clearly documented on the medical clinical records sighted. Documentation demonstrated that the care and support plans are evaluated at least six monthly or more often if required. If a resident is not responding appropriately to the interventions being delivered, or their health status changes, this is discussed with the GP.</p> <p>The multidisciplinary (MDT) reviews are organised by the RNs and families are invited to attend or contribute to the review process. Family and residents confirmed their input into the MDT meeting.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The policy related to exit, transfer or transition states that residents have access to appropriate external treatment and support services. All referrals are clearly documented in the progress notes and in the diary. The family are notified of the upcoming appointment and are invited to attend and assist.</p> <p>In residents' files reviewed information relating to the referral process was sighted. Residents are given a choice of GP when they are admitted. If the need for other services are indicated or requested, the GP sends a referral to seek specialist assistance from the DHB.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The service has a policy related to waste management which identifies how waste products are disposed of to ensure residents, visitor and staff are protected from harm. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.</p> <p>Chemicals sighted are stored securely. Safety data sheets were sighted for the chemicals in use. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 2 August 2016.</p> <p>There is a process in place to identify and manage maintenance both long term and reactive. Electrical safety testing occurs annually and was completed in May 2016 by a registered electrician. Clinical equipment is tested and calibrated by an approved provider at least annually and was last completed in April 2016.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. The facility has ample storage space for all equipment. Regular environmental audits sighted identify that the service actively works to maintain a safe environment for staff and residents. Maintenance is undertaken as required by outside contractors. (Contracts sighted).</p> <p>Outdoor areas have appropriate seating and shaded areas which are easily accessible for all residents including wheelchair access.</p> <p>Interviews with residents and family/whānau members confirmed the environment is suitable to meet their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal</p>	<p>FA</p>	<p>There are adequate centrally located toilet and shower facilities in each wing for residents with separate staff and visitor facilities. All residents' bedrooms have a hand-basin and one bedroom has a full ensuite. All bathroom facilities have privacy locks. Hot water temperatures are monitored and remain within safe limits.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. All bedrooms are single occupancy.</p> <p>Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and stated that privacy is never an issue.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There are three lounge areas, one is a quiet lounge. There is a large exercise hall and chapel which is used for the majority of activities although activities can be undertaken in any of the lounge areas. There are two separate dining areas which open onto a large paved outdoor area with tables and chairs.</p> <p>Residents and family/whānau voiced their satisfaction with the environment.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has documented procedures in place for cleaning and laundry tasks. Chemicals are securely stored and material data sheets are readily available. The laundry is appropriately equipped with clearly defined clean and dirty areas. The equipment in the laundry is checked regularly. Monthly checks are conducted to ensure specific chemical mixes being used create clean and hygienic laundry. This was confirmed in reports sighted from the chemical provider.</p> <p>During interview, residents and family/whānau confirmed they are very happy with the laundry services provided. Interviews with cleaning and laundry staff confirmed they comply with policies and procedures and they are happy with the products used.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. (Last undertaken in April 2016). Staff education occurs during orientation and at least annually related to management of emergency procedures. This is confirmed in the education</p>

<p>emergency and security situations.</p>		<p>schedule sighted.</p> <p>Emergency supplies and equipment include food, water and an emergency generator. The service has a fire service approved evacuation plan dated 23 July 2006 and there have been no changes to the facility footprint since this time. Six monthly trial evacuation drills occur and are well documented. (Last undertaken in May 2016). The service undertook their annual review of the pandemic programme in April 2016 as confirmed by the manager and sighted in documentation.</p> <p>The service also has a small bank of solar heating which can provide hot water in the event of the main supplies failing.</p> <p>Staff are required to check the doors and windows are locked at dusk. Visitors to the facility after this time need to ring the front door bell for entry. Staff and residents stated they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The areas used by residents have at least one opening window which allows ventilation and natural light. Electric and solar heating is used at the facility. Residents confirmed during interview that the facility remains at a suitable temperature throughout the year.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>The service has a documented infection control programme which is reviewed as part of the annual quality review programme. The infection control programme minimises the risk of infections to residents, staff and anyone else visiting the facility.</p> <p>The infection control coordinator (IPCC) is the manager. The infection control coordinator monitors for infections using standardised definitions to identify infections, carries out surveillance activities and monitors organisms related to antibiotic use. Infection control is a standing agenda item in the staff meetings. If there is an infectious outbreak this is reported immediately to staff, management, and where required, to the DHB and public health department.</p> <p>The infection control coordinator interviewed reported that the staff have good assessment skills in the early identification of suspected infections. Residents with infections are reported to staff at the shift handover, have short term care plans developed and documentation in the progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from</p>

		<p>infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. When outbreaks are identified in the community, notices are placed at the entrance not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required.</p> <p>The RNs and caregivers interviewed demonstrated good infection prevention and control techniques and awareness of standard precautions, such as hand washing.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPCC confirmed being responsible for facilitating infection prevention and control activities. The IPCC has attended relevant education on infection prevention and control and advises she liaises with the GP if there are any concerns about a resident with a known or suspected infection.</p> <p>The IPCC is responsible for gaining infection control, infectious disease and microbiological advice and support, where this is not available within the organisation. In the event of an outbreak advice would be sought from the GP, DHB or laboratory services.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>A copy of the infection prevention and control policies are available for staff to refer to as and when required. Staff interviewed confirmed access to policies on infection prevention and control. Staff reported if they had any concerns they would speak to the RN and contact the manager as required. The GP confirmed in interview that he is contacted by staff in a timely manner when the needs of the residents' have changed.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	FA	<p>Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. Education is provided by the DHB infection control consultant and the manager as part of the annual education programmes.</p>

<p>service providers, support staff, and consumers.</p>		<p>Residents and family are provided with advice on infection prevention and control activities via residents' meetings. The residents' meeting minutes included discussion on the importance of hand hygiene.</p> <p>Staff reported on interview they regularly receive education on infection prevention as part of the annual programme and also at handover if a situation arises.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance for infections is carried out in accordance with agreed objectives and priorities that is specified in the infection control programme. The surveillance programme reviewed is appropriate for the size and nature of the services provided.</p> <p>The IPCC explained the surveillance system, the role and responsibilities of the IPCC, and the reporting systems in place. Information gained is reported as part of the quality management system requirements and quality improvement objectives on a monthly basis.</p> <p>Relevant types of infections, such as urinary tract infections, lower respiratory infections, influenza, chest, skin, wound infections and other infections are part of the surveillance programme. Surveillance forms have been developed and implemented for this purpose. Infection reports are completed and reviewed individually by the IPCC. Any immediate trends, advice or information fact sheets are provided back to the service concerned. Additional advice and support on infection control matters can be sought from the DHB or a private infection control nurse consultant.</p> <p>Caregivers reported that they are kept well informed and understood their responsibilities for reporting any signs and symptoms of a resident having an infection to the RN.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint.</p> <p>The service had one bedside rail restraint and no enablers in use at the time of audit. Staff verbalised their understanding and knowledge related to restraint and enabler use during interview.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for</p>	<p>FA</p>	<p>The manager is the restraint coordinator and their job description identifies their lines of accountability for restraint. All staff interviewed are aware of the processes to be undertaken prior to restraint use. Education was undertaken in January 2016.</p>

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.		Policy identifies the approval processes which is implemented by the service. The only current approved restraints are bedside rails.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The assessment process undertaken by the service meets all the requirements of this standard. It is clearly documented in the resident's file reviewed for restraint use. Ongoing assessment for the continued use of restraint for the resident who has had bedside rails in use since 2010 is undertaken at least six monthly as part of the interRAI assessment process. The need for ongoing restraint use is discussed at staff meetings and multidisciplinary meetings.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint is only put in place for safety reasons. Alternative interventions are considered prior to this. Only approved restraints can be used as stated in policy. When restraint is in use it is monitored at a frequency decided by assessment related to identified risk to the resident. The restraint register sighted contains information which allows all episodes of restraint to be readily audited. The register shows that restraint is discontinued when it is no longer appropriate and the service has reduced restraint use from four in 2015 to one in 2016.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is evaluated at least every six months along with all other care provision as part of interRAI assessment process. In the file reviewed restraint was identified under falls risk, mobility and restrictive devices. Annual multidisciplinary meetings which include family/whanau members and the resident identify that an updated annual consent for the use of restraint is signed. If a resident's condition changes and they can be safely managed without restraint, then the restraint is ceased. This is shown in the restraint register and in the resident's clinical file.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	A monthly quality review of all restraint use is undertaken by the health and safety committee which the restraint coordinator attends. The findings are shared at staff meetings. The services progress toward reducing restraint is tracked. Part of the review process includes ensuring the staff education reflects current good practice and meet legislative requirements.

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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.

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

No data to display

End of the report.