

# Queen Rose Retirement Home Limited - Queen Rose Retirement Home

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Queen Rose Retirement Home Limited

**Premises audited:** Queen Rose Retirement Home

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

**Dates of audit:** Start date: 29 June 2016 End date: 29 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:** 23



# Executive summary of the audit

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## 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

Queen Rose Rest Home provides residential services for people requiring rest home level care. All of the 23 beds were occupied on the day of the audit. The manager who has aged care experience has owned the service since 1985.

The audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

Residents and family interviewed praised the service for the support provided.

Improvements are required around neurological observations, training for the infection control coordinator, pain assessments, wound documentation, care plan documentation and medication management.

## 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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The staff at Queen Rose Rest Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The owner is the manager who is supported by long serving staff and a registered nurse.

Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan has goals documented. Policies and procedures provide appropriate support and care to residents with rest home level needs and a documented quality and risk management programme that is implemented.

Staff receive ongoing training and there is a training plan developed and commenced for 2016. Rosters and interviews indicate sufficient staff that are appropriately skilled with flexibility of staffing around client's needs.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme.

There is a secure electronic medication system at the facility.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All staff hold a current first aid certificate.

## 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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The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There are no residents using enablers and no residents using restraint.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (the manager – a registered nurse). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends and discussed at staff meetings.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	39	0	6	0	0	0
<b>Criteria</b>	0	87	0	6	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Discussions with staff (one registered nurse, four caregivers and the activities officer) confirmed their familiarity with Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents and four family members interviewed confirmed the services being provided are in line with the Code.</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 need to make informed choices and give informed consent.</p>	FA	<p>An informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>An informed consent form is utilised by the service provider and is retained in individual resident's records (reviewed). Additional forms, for example for annual influenza vaccinations are in the records. Forms are signed and dated appropriately. All resident files sampled had resuscitation orders however, the general practitioner had not signed all of them.</p> <p>The GP interviewed understood the obligations and legislative requirement to ensure</p>

		competency of residents as required for advance directives and advance care planning. Resident reviews were undertaken six monthly. Reviews of individual residents health status was documented and was retained in personal files.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	All residents have a documented advocate if they cannot self-advocate. Contact numbers for advocacy services are in advocacy pamphlets available in the entrance. Residents' meetings include actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are easily accessible to residents and family. Residents and families interviewed were aware of the complaints process and to whom they should direct complaints, and how to access forms. Four complaints reviewed for 2016 demonstrated comprehensive investigation and responses to the complainant and feedback to staff as needed.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy, in formats suitable for people with intellectual disabilities. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Resident meetings and surveys provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at the service.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. At the commencement of employment, staff sign golden rules and the service code of conduct.

receive services in a manner that has regard for their dignity, privacy, and independence.		Residents are supported to attend church if they wish. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education around this has occurred.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. No residents identify as Māori; cultural needs are addressed in care plans as needed. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning and activities goal-setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed, and family involvement is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of golden (house) rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents, with needs relating to resident at rest home level care. The quality programme has been designed to monitor contractual and standards compliance, and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The registered nurse is responsible for coordinating the internal audit programme. Staff meetings and residents meetings are conducted. Residents and relatives interviewed spoke very positively about the care and support provided. All caregivers complete competencies relevant to their practice and have completed the national certificate in elderly care or level three Careerforce.

<p><b>Standard 1.1.9: Communication</b></p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Relatives interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on five incident forms reviewed and resident files. Resident meetings occur and the registered nurse and the owner/manager have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Queen Rose Rest Home provides residential services for residents requiring rest home level care. On the day of the audit, there were 23 residents, 22 under the Aged Residential Care contract and one younger person (disabled). The owner who has owned the facility since 1985, manages the organisation. A full time registered nurse supports him.</p> <p>The goals and direction of the service are well documented in the business plan and the progress toward previous goals has been documented.</p> <p>The owner has maintained eight hours annually of professional development activities related to managing a rest home.</p>
<p><b>Standard 1.2.2: Service Management</b></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 reported that in the event of his temporary absence the registered nurse oversees the facility with support from the long-standing caregivers.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	FA	<p>The registered nurse and the manager facilitate the quality programme and ensure the internal audit schedules are implemented. The internal audit schedule is implemented. Corrective action plans are developed, implemented and signed off when service shortfalls are identified.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident, and</p>

<p>continuous quality improvement principles.</p>		<p>infection control data collection and complaints management. All quality improvement data is discussed at monthly staff meetings where a comprehensive and resident focussed agenda is discussed.</p> <p>There are policies and procedures relevant to the various service types offered and they are reviewed two yearly. These have been updated to include InterRAI requirements.</p> <p>There is a current risk management plan. Hazards are identified and managed and documented on the hazard register. The manager, who is the designated health and safety officer, has completed training that relates to this role. Health and safety issues are discussed at every monthly staff meeting with action plans documented to address issues raised.</p> <p>There are resident surveys conducted and analysed with corrective action plans developed when required. The most recent during September 2015 recorded that residents are very satisfied.</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>PA Low</p>	<p>The accident/incident process includes documentation of the incident, and analysis and separation of resident and staff incidents and accidents. Five incidents sampled for May 2016 demonstrated appropriate documentation however, the service does not document neurological observations following a head injury. Accidents and incidents are analysed monthly with results discussed at staff meetings.</p> <p>The manager is aware of situations that require statutory reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Five staff files sampled (three caregivers, one registered nurse and one activities coordinator) show appropriate employment practices and documentation. Current annual practicing certificates are kept on file.</p> <p>The orientation package provides information and skills around working with residents with aged care related needs and was completed in all staff files sampled.</p> <p>There is an annual training plan in place and implemented. All five staff files sampled contained a current annual performance appraisal.</p> <p>Residents and families state that staff are knowledgeable and skilled.</p> <p>All staff members have achieved the National Certificate or level three Careerforce in elderly care.</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>	FA	<p>There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts and needs of different individual residents.</p> <p>On call is provided by the full time RN with assistance from a casual RN for weekends and as needed. The manager (non RN) is also available on call. There is also a sleepover security person overnight. Staff, residents and family interviewed confirmed that staffing levels are adequate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. Files, and relevant resident care and support information can be accessed in a timely manner.</p> <p>All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so.</p> <p>Individual resident files demonstrate service integration. Medication charts are in a separate folder with medication and this is appropriate to the service.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation.</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>	FA	<p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident's sampled records. Admission agreements reflect all the contractual requirements. Residents and families reported that the admission agreements were discussed with them in detail by the registered nurse (RN). All residents had the appropriate needs assessments prior to admission to the service. A handout and pamphlet containing information about the service was sighted. The RN ensures that residents are admitted to the service as per contractual requirements.</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>	FA	<p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. A record is kept and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.</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>PA Low</p>	<p>The facility uses an electronic system for medication administration. The staff administering medications complied with the medication administration policies. Procedures were evidenced in the observed medication round. Electronic reports were viewed for 10 residents and reports for errors viewed. Current medication competencies were evidenced in the staff files. A shortfall was identified around storage of expired medications and the identification of eye drops.</p> <p>Medications were stored appropriately with the exception of three eye drops containers that were not labelled with the residents name or opening date and expired medications were not stored securely.</p> <p>No residents were self-administering medications. The self-administration policies and procedures were in place.</p> <p>In response to the DHB email dated 22 June 2016, the service has implemented an electronic medication system. This ensures that the 'as required' medication and medication review dates are appropriately documented.</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>	<p>FA</p>	<p>Residents are provided with meals that meet their food, fluids and nutritional needs. The RN completes the dietary requirement forms on admission and provides a copy to the kitchen and the external food company. Residents' food preferences were identified and this included consideration of any particular dietary preferences or needs. The kitchen folder included a list of resident likes and dislikes. Residents with special dietary needs had their needs identified in their care plans.</p> <p>There are food policies/procedures for food services and menu planning. Food service is supplied by an external food company and is delivered twice a day. There was a four-week cycle menu with dietitian input obtained by the food supplier.</p> <p>Interviews with residents and family members indicated satisfaction with the food service. The servery was adjacent to the dining room and food was served directly to residents. Staff were observed assisting residents with their lunchtime meals and drinks.</p> <p>Fridge and food temperatures were monitored and recorded daily. The meals were well presented and residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weight loss problems are provided with food supplements.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</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>FA</p>	<p>There is a documented policy on decline of entry to the service. When a potential resident's entry to the service is declined, they are referred back to the referrer to ensure that they are admitted to the appropriate level of care provider. The RN reported that the district health board needs assessors and social workers contact the manager to discuss the suitability of the potential resident prior to sending the potential resident's family to view the facility.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>The registered nurse utilises standardised risk assessment tools on admission and the InterRAI assessment tool. Pain assessments were not always completed when required. InterRAI assessments, assessment notes and summary were in place for three of five resident files reviewed. The long-term care plans in place reflected the outcome of the assessments. Cultural, sexuality and intimacy needs have been identified for the residents.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>The long-term care plans sampled were resident-focused and personalised however, care plans did not always document the sufficiently detailed interventions required to meet all current needs. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents/relatives confirmed on interview that they are involved in the care planning and review process. There was evidence of allied healthcare professionals involved in the care of the resident. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed-off as resolved or transferred to the long-term care plan. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Family confirmed they were kept informed of any changes to resident's health status. Family members interviewed expressed satisfaction with the clinical care and that they are involved in the care planning of their family member. Caregivers interviewed state there is adequate equipment provided including continence and wound care supplies. On the day of the audit, supplies of these products were sighted.</p> <p>There were four skin tears, two minor wounds and two surgical wounds being treated at the time of the audit. Wound assessments, treatment plans and regular evaluations had been completed for three current wounds with ongoing evaluations documented. One current wound</p>



		<p>had a STCP in place. The manager/registered nurse interviewed could describe the referral process to a wound specialist or continence nurse. Progress notes and observation charts were maintained. Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour.</p> <p>Resident care plans (short term and long term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity, and weight loss however, do not always document sufficient interventions to meet all assessed needs (link 1.3.5.2). Caregivers interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions at the beginning of each shift.</p>
<p><b>Standard 1.3.7: Planned Activities</b> 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>The service employs an activities coordinator for 30 hours per week. Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The activity therapist interviewed has forty years' experience and displayed an excellent understanding of requirements. Caregivers support all activities.</p> <p>The weekly activities are posted in the rest home and include van outings, bowls, craft, bingo, church services and quizzes. The activity plans sampled were well documented and reflected the resident's preferred activities and interests. Each resident has an individual activities assessment on admission and from this information an individual activities care plan is developed. The activities plan is reviewed six monthly and the reviews documented the resident's progress towards goals. The resident's activities participation log was sighted. Interviewed residents and families verbalised the activities provided by the service are adequate and enjoyable. A resident on a YPD contract is involved in community employment and external activities and was observed enjoying setting lunch tables for resident meals.</p>
<p><b>Standard 1.3.8: Evaluation</b> Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurse evaluates all initial care plans within three weeks of admission. All residents have a long-term care plan and where required these have been reviewed regularly. Not all long-term care plans reviewed were updated as changes were noted in care requirements (link 1.3.5.2). Three residents do not yet require a care plan evaluation. Short-term care plans were not utilised for all short-term care issues (link 1.3.6.1). Care staff document progress notes on every shift. Registered nurse entries in progress notes were evident. The GP completes a three monthly resident review or earlier if required. The family are notified of GP visits and three monthly reviews by phone call and if unable to attend, they are informed of all the changes.</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>	FA	<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. The registered nurse facilitates internal referrals. Family communication records confirm family involvement.</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>	FA	<p>All chemicals were securely stored. Storage areas were locked. Chemicals were clearly labelled and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. During the audit, staff were wearing gloves, aprons and hats when 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>	FA	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness.</p> <p>Both internal maintenance and external contractors undertake maintenance. Electrical safety-test tag system shows this has occurred. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The chair lift to the first floor has annual safety checks.</p> <p>All external areas inspected were safe and contain appropriate seating and shade.</p> <p>Interviews with residents and family members confirmed the environment was suitable and safe 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 hygiene</p>	FA	<p>There are sufficient numbers of toilets and bathrooms for the number of residents in the rest home. Privacy is maximised. All bathrooms and toilets are maintained to a good standard, and they are disability accessible with easy to clean walls and floors. The hot water temperatures are monitored monthly.</p>

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	There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms.
<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	The rest home has a lounge/dining area which is suitable for the residents and the care setting. There is adequate room for facilitating activities. Appropriate comfortable seating is provided. The dining rooms and lounge are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. All furniture is safe and suitable for the rest home residents.
<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	Caregiver staff are responsible for cleaning and laundry service. There are sufficient staff allocated seven days a week to carry out these services. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure this is safe and effective. Where improvements can be made these are implemented. Current safety material datasheets about each product are located with the chemicals. The chemicals are stored appropriately in locked cabinets at all times. The cleaner's trolley is stored in a locked room when not in use.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has an approved evacuation plan. The last fire evacuation drill was held in April 2016. Staff attendance is recorded in the training records. Civil defence equipment and resources are available. The facility has back-up lighting, power and sufficient food, water and personal supplies to provide for its maximum number of residents in the event of a power outage.</p> <p>The emergency plans and security systems meet regulation requirements. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas. A security person sleeps over each night as well as staff ensuring the service is secured each night.</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 rest home has adequate heating. The manager interviewed ensures the heating systems are running smoothly and that appropriate checks are performed.</p> <p>There are sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to promote ventilation and to be secured as needed.</p> <p>The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</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>Queen Rose Rest Home has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control person with support from all staff. Infection control matters are discussed at all staff meetings and management meetings. Education has been provided for staff. The infection control programme has been reviewed annually.</p> <p>In response to a DHB email dated 16th March 2016, following an outbreak during 2014 the following is confirmed:</p> <p>Staff training around specimen taking and use of forms was undertaken at the time of outbreak. The infection control policy includes the need for correct and number of samples for staff affected. The service has a copy of 'Guidelines For The Management of Noro-Virus' published by the Ministry of Health. This publication is integrated as part of their IC suite of policies.</p> <p>An infection control questionnaire for all staff to complete included the use of personal protective equipment, handling infected linen, and effective hand washing. All staff have completed this since August 2015. Additional education has included; Hygiene and personal care (April 2016), hand hygiene (May 2016), outbreak management (May 2015) and chemical safety training (August 2015) included correct use of products.</p> <p>The September 2014 staff meeting documents that infection control and isolation procedures was discussed.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and</p>	<p>PA Low</p>	<p>There are adequate resources to implement the infection control programme. The infection control (IC) person has not recently maintained her practice by attending external updates. The infection control team is all staff through the staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and</p>

information resources to implement the infection control programme and meet the needs of the organisation.		induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The staff orientation programme includes infection control education. The infection control person provides staff in-service education that has occurred in 2016. Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting.
<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>	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The manager is the designated infection control person. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly summary and then analysed and reported to staff meetings.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence, such as a lap belt in a wheelchair.

## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Incident forms are completed for any incident or near miss. However, neurological observations are not undertaken following a head injury.	The incident form following a head injury did not document neurological observations. Discussion with the registered nurse evidenced that neurological observations are not routinely undertaken post head injury.	<p>Ensure all head injuries have neurological observations completed.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and</p>	PA Low	All facility medication charts were reviewed and met legislative requirement. The GP dated and signed discontinued medications. All ‘as required’ medications had an indication for use. Current medications were stored securely but not expired	<p>Expired medications are stored in an unlocked office for return to pharmacy.</p> <p>Opened eye drops did not identify the date the bottles were opened and eye drops in use on the trolley did not</p>	Ensure all expired medication is stored securely prior to return to pharmacy.

appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications, and eye drop labelling was inadequate. .	evidence the resident's name.	Ensure eye drops are labelled with the residents name and the date the bottle was opened.  30 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	All resident files reviewed had initial assessments and risk assessments completed on admission. All of the files reviewed had an InterRAI assessment however not all files evidenced all required assessments.	Two of the five files reviewed did not evidence pain assessments for residents requiring PRN pain medications.	Ensure pain assessments are completed and reviewed for residents on PRN medication.  90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Five resident files were reviewed. The initial care plans have been developed within 48 hours of admission. The long-term care plan was developed within three weeks of admission. There was evidence of review in all files; however, the long-term interventions did not include sufficient detail to guide staff. Insufficient detail was evidenced in relation to pain management, continence, and self-medication, wound management, sleep and intimacy management. Staff interviewed were familiar with and providing the required cares so the risk for this shortfall is assessed as low.	Three of five resident files did not evidence that care plan interventions provided sufficient detail to guide care staff.  1. One resident care plan was not updated to reflect sleep, wound management and intimacy interventions.  2. One resident care plan did not include non-medical pain management interventions.  3. One resident care plan did not include continence management interventions.	Ensure that the interventions in the care plan reflect the resident's current needs as identified through assessments and progress notes.  60 days

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Wound assessment and wound management plans were not fully documented for all wounds. Three of eight wound assessment and wound management plans were documented but one of these was incomplete. Short-term care plans were in place for one of eight identified wounds. One wound had been transferred to the long-term care plan.</p>	<p>Wound care documentation was incomplete for six out of eight wounds. Five out of the eight wounds had not been assessed and did not have treatment plans in place. Six out of the eight recent wounds did not have short-term care plans in place to document the interventions required. Two out of three wounds with treatment plans did not document the frequency of treatment. Five out of eight wounds did not have evidence of regular reviews.</p>	<p>Ensure that wound assessment and management plans are fully documented and followed, and that all wounds have interventions documented in either a short-term care plan with regular documentation reviews or in a long-term care plan.</p> <p>60 days</p>
<p>Criterion 3.2.1</p> <p>The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.</p>	<p>PA Low</p>	<p>The infection control coordinator has completed substantial external education but has not completed infection prevention and control training in the past two years.</p>	<p>The infection control coordinator has not updated infection control training in the past two years.</p>	<p>Ensure the infection control coordinator maintains a current knowledge of infection control best practice.</p> <p>90 days</p>



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

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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.

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End of the report.