# Glenlaurel Care Limited - Lexham Gardens Rest Home

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Glenlaurel Care Limited

**Premises audited:** Lexham Gardens Rest Home

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 August 2016 End date: 24 August 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:** 47

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Lexham Gardens Rest Home provides rest home and hospital care for up to 50 residents. The service is operated by Glenlaurel Care Limited and managed by a director/manager and a clinical nurse manager. Residents and staff spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff records, observations and interviews with residents, families, management, staff, contracted allied health providers and a general practitioner.

This audit has resulted in the identification of one area requiring improvement relating to self-administration of medications.

## Consumer rights

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| --- | --- | --- |
| 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. |

The residents receive services that respects their rights. The staff demonstrated knowledge and awareness of their obligations of consumer rights legislation. The residents are treated with respect, dignity and are not subject to abuse, neglect or discrimination.

There are appropriate processes and procedures implemented to ensure residents who identify as Maori, or any other culture, have their individual beliefs respected and acknowledged. If required, the service can access an interpreter.

The service provides an environment that encourages good practice, which includes evidence-based practice.

Residents and families receive full and frank information and open disclosure from staff. The residents, their families or enduring power of attorneys (EPOAs) are involved in the care planning, decision making and consent processes. Where there is an advance directive, the staff act on the decisions.

There are no set visiting hours and residents have access to visitors of their choice. All visitors commented on the welcoming nature of the service.

The manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

## Organisational management

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| 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. |

Glenlaurel Limited is the governing body and is responsible for the service provided at this facility. A business and quality and risk management plans are documented and include the scope, direction, objectives, values and mission statement of the organisation. The values and mission statement are displayed at reception. Systems are in place for monitoring the service provided. The manager reports to the governing body.

The facility is managed by an experienced and suitably qualified manager.

A quality and risk management system is in place which includes internal auditing, monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation and resident/family surveys. Quality improvement is maximised and outcomes reported to staff with discussion of trends and follow-up where necessary. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed and implemented.

A suite of policies and procedures cover the necessary areas, are current and implementation is evident.

The human resources management policy is based on current good practice and guides the system for recruitment and appointment of staff. Orientation is provided to all staff and education is ongoing. Registered nurses are encouraged to undertake post graduate study relevant to their role.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The clinical manager is on call after-hours.

Resident information is uniquely identifiable, accurately recorded and securely stored. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

## Continuum of service delivery

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

The entry requirements for rest home and hospital level of care are clearly documented. Residents and families receive accurate information on admission to the service. If entry to the service is declined, a record is maintained and the potential resident and/or their family/whānau referred to a more appropriate service.

The processes for assessment, planning, provision of care, evaluation, review, and exit from the service are provided within time frames that safely meet the needs of the resident and contractual requirements. The service has implemented the required electronic assessment tool (interRAI). The care plans described the required support and/or intervention to achieve the desired outcomes. The evaluation record showed the progress the resident is making towards meeting their goals. Where progress is different from expected, the service responds by initiating changes to the care plan or with the use of short term care plans. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

Referral to other health or disability service providers is facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessments to facilitate any discharge or transfers to other providers.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents.

There are processes in place for safe medicine administration. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. There are some residents who self-administer their medications.

The families and residents report satisfaction with the meal services. The menu is reviewed by a dietitian.

## Safe and appropriate environment

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

The facility has been purpose built. There are single and double rooms including some with ensuite bathrooms, all of adequate size to provide personal care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A maintenance programme is implemented.

Communal areas are spacious and the facility is maintained at a comfortable temperature. There is a large external courtyard with seating and shade is available in the summer.

Cleaning and laundry services are provided by employed and contracted providers. These services are monitored through the internal audit system and resident satisfaction process. Residents and family interviewed confirmed the facility is kept clean, well ventilated and warm.

Emergency policies and procedures provide guidance for staff in the management of emergencies. There is an approved fire evacuation plan and fire evacuation drills are conducted. There are sufficient supplies available on site for use in the event of an emergency or an infection outbreak.

## Restraint minimisation and safe practice

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

The restraint minimisation and safe practice policy complies with the standard. The organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers and four restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored.

A comprehensive assessment, approval and monitoring process with regular three monthly reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training and staff interviewed had a good understanding of the restraint and enabler processes, managing challenging behaviour and safe and effective alternatives to restraint. Safety is paramount and is promoted at all times for residents.

## Infection prevention and control

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

There are appropriate systems in place for infection prevention and control. The infection control coordinator attends and provides regular staff education related to infection prevention and control. The documented policies and procedures for the prevention and control of infections are regularly reviewed. The infection control programme is reviewed annually.

Surveillance for infections is conducted monthly. Results of surveillance are collected, collated and analysed to identify any trends and prevent or minimise further infections.

## 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 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 100 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. New residents and families were provided with copies of the Code as part of the admission process. Staff demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The residents' files reviewed had consent forms signed by the resident or their next of kin/enduring power of attorney (EPOA). The files contained copies of any advance care planning and the resident’s wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them. Residents and family expressed no concerns related to informed consent. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The residents and families reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is conducted as part of the in-service education programme. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | There are no set visiting hours and visitors are encouraged to visit. Residents are supported and encouraged to access community services independently or with visitors. The residents and families reported that the service is ‘like a second family’ and families feel very welcome to visit. One family commenting that even though the facility is not located close to where they live, they are ‘very satisfied’ with the care and services and would not like their relative in a facility closer to where they live as their relative is ‘so happy’ at Lexham Gardens.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The manager is responsible for complaints and there is a system in place to manage the complaints process. The complaints policy and procedure meets the requirements of Right 10 of the Code. Complaints forms are accessible in different localities around the facility and at reception. The policy is displayed on the notice board to guide staff.Compliments received by email and cards are kept in a folder. There are two complaints registers one for verbal complaints and one for written complaints. All are dealt with individually and are signed and dated when closed out. Currently for 2016 there have been five verbal and three written complaints. There are no external complaints at the time of the onsite audit. Residents and families interviewed demonstrated an understanding and awareness of the right to make a complaint.All complaints are collated on a monthly basis and graphs are developed and information is fed back to all staff. The graphs are framed and displayed in the staff room for staff to view. Staff interviewed confirmed these discussions at the staff meetings and minutes of the staff meetings reviewed confirmed this. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The Code is discussed with family members at the time of admission and information is also available in the information booklet. Information was also displayed about the Nationwide Health and Disability Advocacy Service. The residents and families reported no concerns about the staff not respecting the residents’ rights.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are four rooms that have the capacity to be shared rooms (currently three of these are used as single rooms), with the other room shared by a married couple. The curtain tracks and the dividing curtains are available to be installed if the residents in this room wish this. The current couple report they do not want the dividing curtain installed. All other rooms are single occupancy. The files reviewed reflected that care is provided that is responsive to the individual cultural and spiritual needs of each resident. The services are planned so the residents can maintain as much independence as possible. The residents and families reported satisfaction with the care provided and have no concerns about abuse or neglect. Staff demonstrated knowledge on identifying any suspected abuse and know who to report to if they suspect abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Residents who identify as Maori have their individual needs met, with guidelines for tikanga best practice available. The clinical manager reported that there were no barriers to Maori residents accessing the service. The staff demonstrated knowledge of the importance of whanau in the care and support of residents who identify as Maori. There are no current residents that identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The resident’s individual cultural values and beliefs were recorded in the care plans. All files evidenced the care was developed in consultation with the family. The residents and families interviewed reported that the service meets their individual needs or those of their relatives. Staff demonstrated knowledge in respecting and meeting the individual cultural needs, values and beliefs of each of the residents. A file was sampled and reviewed of a resident who has specific cultural values and beliefs, which included dietary requirements.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff individual employment contracts have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and families reported they have no concerns about discrimination. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. There is regular in-service education and staff access external education that is focused on aged care and best practice. This included pressure area prevention. The services have implemented specific best practice and evidenced based programmes for pressure area prevention, walking for rehabilitation and minimising reoccurrence of urinary tract infections. Staff reported that they were satisfied with the relevance of the education provided. Best practice with wound management was sighted in a resident's file reviewed. The residents, families and GP all expressed high satisfaction with the care delivered. Particular praise for the knowledge, skills and best practice expectations of the facility manager and clinical manager were expressed.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service promotes an environment that optimises communication through the use of interpreter services as required. Staff education has been provided related to appropriate communication methods. All residents are able to effectively communicate with the staff. There are a number of multi-lingual staff. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documentation of open disclosure following incidents/accidents was evident. The families all reported that they are informed of any changes with their relatives.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service has a suite of policies and procedures on leadership, management, quality and risk which clearly describes organisational management. Documentation identifies the core purpose, vision, goals and values of the organisation. The service mission statement and values are displayed on the wall at reception.There is an operational flowchart available in the quality manual. The manager is responsible for the quality management and is responsible for the day to day management of the facility and service provision. The manager has had 17 years of experience as a registered nurse, but currently no longer maintains her annual practising certificate. The last ten years have been involved in residential aged care and managing a variety of service settings. The manager has been in this position since October 2015 and has completed and attended relevant training for this position. Both staff and families reported an improvement in the service since the change of management. The service has a contract for providing respite care. Twenty four residents are rest home level care and 23 residents are hospital level care on the first day of this audit. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the absence of the manager the clinical nurse manager deputises for the manager. The clinical nurse manager has been employed in this role since October 2015. The annual practising certificate for the clinical nurse manager was validated. The clinical nurse manager is suitably qualified and has been a registered nurse in New Zealand since December 2012. The personal record sighted for the clinical nurse manager evidenced further qualifications had been attained and relevant clinical training for nursing in the aged care sector had been attended. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality and risk system that reflects the principles of continuous improvement by developing goals and objectives. Level of risk and consequence are detailed. The service has a commitment to achieve ongoing compliance by fulfilling the domains of quality such as efficiency, effectiveness, safety, responsiveness and accessibility.Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators are discussed at the management and staff meetings held monthly. Staff interviewed reported their understanding of quality and risk and the significance of reporting incidents/events, infection, complaints, falls, pressure injuries and other audit activities.A health and safety manual is available to guide staff. Risks are identified in the risk register maintained by the manager and the manager interviewed is fully informed of the Health and Safety at Work Act (2015) requirements and these are reflected in the training and policies implemented.Corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring.Policies and procedures are relevant to the scope and complexity of the service and reflect current accepted good practice and cover all necessary aspects of the service and contractual requirements. All documents are controlled by the manager. There is a process for archiving documents that no longer are required. Records are stored appropriately.The families interviewed appreciated the three monthly newsletters with updates of any changes, events, activities and family meetings arranged. Family/resident surveys are developed and the first survey completed on nursing service and the food management service was implemented July 2016. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Policies and procedures are in place which identify that all adverse, unplanned or untoward events are recorded and followed through by the service, inclusive of health and safety, human resources, infection control, pressure areas and complaints that are reported to the coroner, Ministry of Health (MoH) or to the District Health Board (DHB). Section 31 is used to report notifiable events to the MoH and DHB if and when required. The manager advised there have been no notifications of significant events since taking over the business in October 2015. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, actions developed and actions are followed-up in a timely manner. Meeting minutes reviewed show discussion in relation to any trends, action plans and improvements made. There is an open disclosure policy for staff to follow and the accident/incident forms identify family/whanau are informed. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | The organisation has documented processes related to human resources management to ensure good employment practice is undertaken and that all legislative requirements are met. Position descriptions reviewed were current and defined key tasks and accountabilities for all roles. The recruitment process includes police vetting and reference checks, and validation of qualification and annual practising certificates (APCs), where required for all health professionals, inclusive of allied health professionals contracted to the service. A sample of staff records reviewed confirmed the organisation`s policies are implemented and records are maintained by the manager.An orientation process is available and covers the essential components of the service provided. Staff reported that the orientation process prepared them well for their role and a `buddy` system worked effectively. Staff records reviewed showed documentation of completed orientation. There is a process developed and implemented for staff appraisals to be completed three months after commencement of employment and annually.InterRAI is now embedded into the service. All resident records evidence interRAI summaries. A schedule is available and reviews are current and up-to-date.All staff receive training and records are maintained for each staff member and were reviewed. There is an education plan for the year and monthly education is displayed for staff. Education is provided as in-service education in-house and staff are also able to access education externally. All relevant staff have completed medication competencies. Care staff have completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider`s agreement with the DHB. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on good practice. There is a clinical nurse manager on duty on the day shift Monday to Friday and two registered nurses, four healthcare assistants and one care manager. On the afternoon shift there is one registered nurse and four healthcare assistants and on night one registered nurse and two healthcare assistants. The manager interviewed stated that when the hospital residents increase to 25 (currently 23) an additional registered nurse will be assigned to the afternoon and night shifts.Care staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them. Team work is encouraged.Residents and families interviewed reported that there was enough staff on duty to provide safe care. Observations during the audit confirmed adequate staff cover is provided.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files identified that information is managed in an accurate and timely manner. Health information was kept in secure areas in the staff area and these were not accessible or observable to the public. There was no private information on display in the facility. All records pertaining to individual residents demonstrated they are integrated. The archived records are securely stored onsite. The resident’s progress notes have entries at least each shift for the hospital level of care residents and at least daily for the rest home residents. A signature verification log is also kept. The progress notes record the date, time, interventions, signature/or initial of the staff member and their designation. Though the name of the staff member was not always recorded on each of the progress note entries, the staff have now commenced this, including printing their name along with their signature and designation.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The facility manager manages entry to the service. The enquiry form records all enquires and if the potential resident has an appropriate assessment for rest home or hospital level of care. The resident information handbook contains accurate information about the service. All residents’ files contain an appropriate needs assessment. The service updates any vacancy on the Eldernet website each weekday. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | When admission has been required to the acute care hospital, the service utilised the DHB’s transfer form/envelope. The referral process documented any risks associated with each resident’s transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. Along with the transfer form/envelope, the RN reported that the service also provides a copy of any other relevant information.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | The observed medication procedures are implemented to meet legislative and best practice requirements. The medications are stored in the locked medication trolley. Medications that require refrigeration are stored in a medication fridge. The temperature for this fridge has been regularly recorded. The processes for controlled drug management meet requirements. There are no standing orders. Four of the residents self-administer some of their medications (inhalers). There is an area for improvement to ensure the self-administration competence is reviewed at least three monthly. . The medications are individually prescribed for each resident. There is no bulk supply of medications. The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy by the RN. The medication charts and prescriptions have the required information and are either hand written by the GP or a pharmacy generated medication chart that is signed by the GP. The three monthly medication reviews are recorded in the residents file and not on the medication chart. All staff who administer medications are assessed as competent to do so. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a four-week rotational menu that has summer and winter variations. This menu has been reviewed by a dietitian in the last 12 months. Residents with specific nutritional needs have these met. The kitchen staff receive a copy of the nutritional requirements for each resident. Residents are routinely weighed monthly or more frequently if there is a clinical need. Nutritional supplements are available to residents assessed as requiring these. The RN and residents/families report there have been no issues with unintentional weight loss. The kitchen services are based on the food safety principles. There are appropriate processes in place for the purchasing, preparation and disposal of food that complies with current legislation and guidelines. The kitchen staff have food safety training. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The facility manager reported if the service is to decline entry to a potential resident, this is recorded. When entry is declined, the referred, prospective resident and family are informed of the reason why. The service had an enquiry regarding a bariatric resident/ The service did not have an appropriate room available for the resident and the referrer was informed of this. The admission agreement is developed through an aged care association that is then personalised to the service. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service provides rest home and hospital level of care, should the needs of the resident increase beyond this level, the resident is reassessed and referred to a service that is better able to meet the higher level of need. The service has had occasions where residents have been required to transfer to a service providing dementia or psychogeriatric level of care.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The assessments and reassessments are conducted using the electronic interRAI assessment process. All files have an initial interRAI assessment. The service also uses their own paper based assessments for additional needs that are identified through the assessment process; this includes behaviour assessments, nutrition, falls, wound assessment, pressure injury risk. Where there is a greater need or risk, reassessments occur more frequently such as monthly falls risk, risk of malnutrition assessments or pain assessments, that are conducted at each PRN (pro re nata – ‘as required’) medication administration. There is a summary of the assessed needs of the resident and these are then documented on the care plan. The files record and residents/families report that the care provided meets the resident’s needs. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident’s specific needs, goals/aims and staff interventions required to address those needs. The care plans evidenced family consultation and input into their planning. There are specific care plans developed for falls management, pressure injury prevention and minimising reoccurrence of challenging behaviours. The residents and families reported satisfaction with the care and with specific management of their relative’s medical conditions. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The provision of services and interventions are consistent with meeting the needs of the residents. The resident’s records are individualised and personalised to meet the assessed needs of the resident. The care was observed to be flexible and focused on promoting quality of life for the residents. All the residents and families reported satisfaction with the care and service delivery. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The residents are included in meaningful activities at the care facility. There is an activities coordinator Monday to Friday and staff assist with the planned and diversional activities over the weekend. The staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents. The activities programme covers physical, social, recreational and emotional needs of the residents. The residents were observed to be participating in meaningful activities both inside and out in the grounds of the service during the audit. The residents and families reported overall satisfaction with the level and variety of activities provided. Residents were observed to be going offsite with family/friends. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluations are conducted at least six monthly and recorded on the care plan. The service uses the built in evaluation scores when the service reassesses the resident using the interRAI assessment as part of the evaluation process. The care evaluations are conducted for all the residents’ needs and recorded how each of the resident’s goals have been met over the past six months. When there are changes in the resident’s needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Each of the residents is able to maintain their own GP if available, with a facility GP available. The RN or GP arranges for any referral to specialist medical services when it was necessary. The resident’s files have appropriate referrals to other health and diagnostic services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances were in place and any incidents are reported in a timely manner. Policies are linked to the infection control programme The chemical storage cupboard is locked and all containers are labelled. Appropriate signage is available and displayed as necessary. Material data sheets are available in all service areas and accessible to the staff. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. A spills kit is located near the main lounge and staff interviewed knew what to do should any chemical spill/event occur.There is provision and availability of protective clothing and staff were observed using protective equipment appropriately, such as disposable aprons, hats and gloves.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness that expires 4 June 2017 is publically displayed. Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for purpose. There is a maintenance programme in place for the building, plant and equipment, and renovation. Testing and tagging of essential equipment is current and on the maintenance plan. This was confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.There are external areas available that are safely maintained and are appropriate for the resident group. The environment is conducive to the range of activities undertaken.Residents interviewed confirmed and were observed to move freely around the facility and that the accommodation met their needs. Staff and residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms have a toilet and hand-basin. Twenty five individual bedrooms also have a shower in the ensuite. There are adequate numbers of additional showers available in close proximity to bedrooms.There are only four small bathrooms that are not able to be used for hospital level residents. There is a visitors’ toilet and staff have designated facilities provided. Appropriate secured and approved handrails are provided in all toilet/shower areas to promote residents’ independence.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | There is adequate personal space provided to allow residents and staff to move around within their rooms safely. Where rooms are shared approval has been sought. Rooms are personalised with furnishings, photos, paintings and other personal items displayed. Mobility aides such as walkers and wheelchairs can be safely manoeuvred in all individual rooms and service areas. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are adequate spaces for residents to enjoy activities, dining and relaxing, that are easily accessible by residents. Residents are able to access areas for privacy when required. Furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely. Residents reported they enjoy their environment. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Personal laundry is undertaken by care staff who demonstrated sound knowledge of the laundry processes, or by family members if requested. The main laundry services are maintained off site by a contracted provider. Residents and family interviewed reported the laundry is managed well and their clothes are returned in a timely manner.The laundry is designed appropriately with clean and dirty flow. There is a lockable cupboard with key pad access for all cleaning and laundry chemicals, and all are appropriately labelled. The cleaner`s trolley can be stored away when not in use for safety purposes. Cleaning staff receive training and product data sheets are available.Cleaning and laundry processes are monitored through the internal audit programme.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and procedures for emergency planning and security are displayed and known to staff. Disaster and civil defence planning guidelines are documented to guide staff in the event of an emergency or fire. The current fire evacuation plan was updated and approved by the New Zealand Fire Service on the 27 March 2000. Trial evacuations take place six monthly, however, due to the new service providers taking over the business in October 2015, three monthly fire drills have occurred March and June 2016 to ensure all staff have received the appropriate training. The staff orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.Adequate supplies in the event of an emergency, including food, water, blankets, mobile phones, batteries, torches and a gas BBQ were sighted and met the requirements for 50 residents. Three large storage bins are located outside the building which are accessible when required. Three monthly checks of resources are documented. Emergency power in the form of a generator is available on site. Emergency lighting is regularly tested.There is a call bell system to alert staff in each bedroom, bathroom and all service areas. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. A security surveillance system is in place. Staff check the facility during the evening and night at predetermined times.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All rooms have electric heaters. All residents` rooms have adequate windows to provide natural light. Many have doors that open onto the outside central courtyard. A heating system is provided in all rooms and service areas and a company is contracted to check and change filters three yearly.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The clinical nurse manager is the interim infection control coordinator. There is one other RN who is currently being trained for the role. They both have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and RN meetings, at which the senior management are present. The directors are informed of quality, risk and infection control issues. The infection control programme has been reviewed in the last year. There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. The staff demonstrated good knowledge and application of infection prevention and control techniques. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control matters are discussed at the monthly staff and RN meetings. If the infection control coordinators require additional advice or support regarding infection prevention and control they can access this through the DHB, GP or diagnostic services. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies and procedures have been developed by an aged care consultant. The service also has resources from a specialist infection control consultancy agency, including resources for management of outbreaks, orientation of staff and an internal audit programme. The policies and procedures cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. These policies are appropriate to the services offered by the facility. All staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator conducts most of the infection control education. There are some visiting specialists who provide infection control education. The house manager and RN reported that the current infection control coordinator demonstrated current knowledge in infection prevention and control. The infection control coordinator has attended ongoing education on current good practice in infection prevention and control. As required, infection control education is conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene when assisting with toileting. The family newsletter also covers infection prevention and control information.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is monthly collection, collation and analysis of infections. The service uses standardised definitions, applicable to aged care, to identify infections. The type of surveillance undertaken is appropriate to the service. Data is collected on urinary tract infections, influenza, skin infections and respiratory tract infections.The infection data reviewed for 2016 records the collation, analysis, graphing and trending of the infection data. The analysis includes comparisons with the previous month, reasons for any increase or decrease and actions, advice and recommendations for reducing infection occurrence. The outcomes are fed back to the staff at the next staff meeting and RN meeting. With an increase in urinary tract infection in March 2016, the service has implemented a specific programme for the management of residents who are at risk of urinary tract infections. Urinary tract infections have decreased with these actions that have been implemented.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service has policies and procedures for restraint minimisation and safe practice. There are clear definitions of a restraint and an enabler. There are appropriate policies and procedures to guide staff actions related to restraint and enabler use. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated sound knowledge and understanding of the organisation`s policies, procedures and practice and the responsibilities of this role.On the day of the audit, four residents were using restraints and four residents were using enablers, which were the least restrictive and used voluntarily at the request of the resident. The service has a robust process which ensures the on-going safety and wellbeing of the resident.Restraint is used as a last resort when all alternatives have been explored. The approval, reviews and monitoring systems were evidenced in the residents’ files reviewed. Approval group meeting minutes were available. Regular discussion occurs for all residents who have approved restraints. Staff interviewed understand the restraint minimisation and safe practice process. |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | The restraint approval group, made up of registered nurses, the clinical nurse manager, the manager and the general practitioner are responsible for the approval of the use of restraints and the restraint process, as defined in policy. It was evident from review of the restraint register, approval group meeting minutes, review of residents’ files and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.There is evidence of family/whanau/EPOA involvement in the decision making process, as is determined by policy. The use of a restraint and/or an enabler is included in the care planning process and is evaluated six monthly or more often if required. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator (a registered nurse), interviewed was well informed about this role. Assessments for the use of restraint were documented and included all requirements of the standard. The initial assessment is undertaken by a registered nurse and with the restraint coordinator`s input. The family/whanau are also involved. The registered nurse interviewed/restraint coordinator described in full the assessment process. Families interviewed confirmed their involvement. The general practitioner interviewed is involved in the final decision on the safety and use of restraint.All aspects in the review/evaluation process are considered, for example, the identified underlying aetiology, history of restraint use, cultural requirements, alternative de-escalation strategies and any identified risks. The long term care plans are updated and the desired outcome to ensure resident`s safety and wellbeing is documented. Completed assessments were sighted. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | All approved restraint is only used as a last resort for safety reasons. The use of restraint is clearly minimised and the restraint coordinator was able to describe how alternatives to restraints are discussed with staff and family members before use of a restraint is implemented.When a restraint is in use, monitoring occurs at the designated timeframes to ensure the resident is safe and that dignity and privacy is maintained and respected. Advocacy and support is available and this is documented in the individual resident`s file in the care plan and on the monitoring forms reviewed.A restraint and enabler register is maintained and updated monthly and reviewed at each restraint approval group meeting. Sufficient information is documented with sufficient information to provide an auditable record.Staff receive training at orientation and this is ongoing. Training on the policies and procedures and in related topics, such as challenging behaviour management and de-escalation techniques, occurs. Staff interviewed understand that the use of restraints is to be minimised and safety was paramount. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | Reviews are undertaken three monthly, rather than six monthly, until all staff have completed the restraint minimisation and safe practice training requirements. Review of resident`s files evidenced the individual use of restraints/enablers is reviewed and evaluated during the care plan and interRAI reviews. All reviews are discussed at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation was completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint approval committee currently undertakes three monthly reviews of all restraint use which includes all requirements of this Standard. Reports are completed and individual use of restraint is reported to the manager and staff meetings on a monthly basis. Minutes of meetings reviewed confirmed this occurred. The restraint reports reflect analysis and evaluation of the amount and type of restraint use in the facility, whether alternatives to restraint have been considered appropriately, the effectiveness of the restraint/enabler in use, staff education and competency and any feedback from the GP, staff and families is considered. The internal audit process includes restraint minimisation and safe practice. Any improvements are documented and changes to policy, procedures and education are implemented if indicated. There is a downward trend in use of restraint and service providers were fed back this information which is displayed in the staff room.  |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There are processes in place to facilitate self-administering of medications. This includes an assessment to ensure the resident is physically and cognitively able to self-administer their medications. Four residents currently self-administer their PRN inhalers and three of these assessment are over three months old (ranged from four months six months). There have been no significant changes in these resident’s physical or cognitive ability to self-administer their medications. The medicines guidelines for residential aged care require the capacity assessments to be completed at least three monthly. | The last self-administration assessment for three of the four residents who are assessed as competent to administer some of their mediations (inhalers) were conducted longer than three months ago.  | Provide evidence that residents who self-administer their medications have reviews at least every three months and have a capacity assessment to assess cognitive and physical ability to self-administer their medications.90 days |

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

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

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

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

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End of the report.