

Ohope Beach Care Limited - Ohope Beach Care

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 HealthShare 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: Ohope Beach Care Limited

Premises audited: Ohope Beach Care

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

Dates of audit: Start date: 12 October 2016 End date: 13 October 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: 32

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ohope Beach Rest Home provides residential care for up to 36 residents assessed as requiring rest home or dementia level care.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager is responsible for the overall management of the facility and is supported by the clinical manager. Service delivery is monitored. The service has had the input of two consultants to support continuing quality improvement. The service has addressed most improvements required at the surveillance audit with a plan in place to address the remaining requirement.

An improvement is required to the review of care plans.

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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Consumer rights are respected during service delivery. Staff have knowledge and understanding of the rights of residents and consumer rights legislation. Services are provided in a manner that is respectful of residents' rights. The privacy of residents is respected. Residents who identify as Māori have their needs met. The individual values and beliefs of residents are documented and respected by staff. Staff communicate effectively with residents and their families and friends. Open disclosure is practiced. Resident consent is sought verbally and in writing where appropriate. Residents and relatives have access to advocacy services. Staff encourage residents to maintain links with their family/whanau and community. There is a system of complaints management in place.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The director is involved in developing and monitoring the annual business plan with the facility manager. The facility manager is supported by a clinical manager and another registered nurse, all of whom are employed full-time. There is a documented quality and risk management system in operation. Assistance in policy development is provided by an external contractor. There is an established system of adverse event reporting in place and management understand their statutory and contractual reporting requirements. Human resource management processes are conducted in accordance with good employment practice. Staffing levels meet and exceed the minimum requirements specified in the contract for aged residential care. Resident information is managed confidentially. Resident files are a mix of electronic and paper-based records. Both registered nurses are using interRAI software.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks of admission. Each resident has a current interRAI assessment and care plan. Care plans are expected to be reviewed every six months. The resident response to treatment is evaluated and documented. Relatives are notified regarding changes in a resident's health condition.

An activities programme is documented and displayed in each area. The activities coordinators provide activities in the rest home and in the dementia unit with 24-hour activities plans in place for each resident in the dementia unit.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. Medication competencies are completed annually for all staff that administer medications.

The facility utilises summer and winter menus with these reviewed by a dietitian. Residents and family expressed satisfaction with food services.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and an approved fire evacuation plan. Services are provided in a clean, safe environment. Waste and hazardous substances are managed appropriately. The physical environment is appropriate and fit for purpose. There are adequate toilets and showers. The rooms' sizes are adequate to meet the needs of residents. There are communal areas for dining, recreation and relaxation. Cleaning and laundry services are performed onsite by dedicated staff. The service has essential, emergency and security systems in place. The building has plenty of natural light, safe ventilation and heating systems to ensure the temperature is maintained within a comfortable range for residents.

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 restraint minimisation and safe practice programme defines the use of restraints and enablers. There are no residents using restraint or enablers and all other alternatives are used prior to considering restraint as an option. The clinical manager oversees a restraint-free environment although there are templates and processes in place should restraint or the use of an enabler be required. Staff members receive annual training regarding management of challenging behaviour including de-escalation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The clinical manager is the infection control coordinator with policies documented to guide practice. The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. A surveillance programme is in place to monitor infections across the facility. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files. The infection control coordinator has had training around infection control.

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	43	0	1	0	0	0
Criteria	0	90	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff receive training in the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights' (the Code) at orientation and during refresher training. Interviews with staff confirmed they understood resident rights. Care staff were observed interacting respectfully and communicating appropriately with residents. Staff encourage residents to make choices demonstrating their knowledge of residents' rights. Residents and family members interviewed could verify that their rights are upheld.</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>The resident files reviewed include a signed general consent form with family signing this if the resident is not competent to complete the form. The informed consent form records consent for a range of situations including the collecting and storage of resident information.</p> <p>The general practitioner determines if the resident is competent to sign an advance directive. The advance directive is signed by residents deemed competent or the general practitioner who may make a medical decision regarding resuscitation. Residents and family participate in assessment, care planning and care evaluations.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There are appropriate policies in place and brochures on display regarding advocacy/support services. Residents and family interviewed confirm that advocacy support is available to them if required, and that information on how to access the Health and Disability Advocate is included in the information package they receive on admission.</p> <p>Staff interviewed have an understanding of how residents can access advocacy/support persons. Staff attend education on the Code and advocacy and complaint management are included in the in-service education programme.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are documented visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Visitors are required to sign in and out via a register. The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs, including reading of the newspaper each day.</p> <p>Residents and family members interviewed confirm that residents have access to visitors of their choice, and confirm that residents in the rest home and dementia unit are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Some residents go out independently on a regular basis.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures refer to the Code and include timeframes for responding to a complaint. Complaint forms are available in the facility and family and residents interviewed know where they can get a form.</p> <p>There is a complaints register in place includes space for recording the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. There have been no complaints received since the previous audit in January 2016. There are no concerns currently being investigated by the Health and Disability Commission (HDC) or other external authorities.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family members have open access to talk to the management and staff at any time. Residents and family interviewed confirmed that they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility's</p>

		<p>admission package prior to the resident's admission.</p> <p>Information on the Code and the Nationwide Advocacy Service are displayed and are available at the facility. This information is included in the information pack provided on admission to the facility. Residents interviewed confirm they have access to an independent advocate if needed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed are aware of the need to respect the privacy of residents and to respect their belongings. Needs and values of residents are documented.</p> <p>Residents were observed being treated with respect by staff during this audit and these findings are confirmed during interviews with residents and family members.</p> <p>Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Activities in the community are encouraged and several residents attend community events independently. Church services are held on site as part of the activities programme. Outings in the van occur regularly. Families transport their family member to some events. Staff and family will transport to appointments.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Maori Health plan was updated in September 2016 in consultation with staff who identify as Māori. The plan includes guidelines for the provision of culturally safe services for Māori residents that includes information on cultural awareness, cultural safety, and the importance of whanau.</p> <p>There are currently residents in the facility that identify as Māori and the facility manager describes the processes they follow when a resident who identifies as Māori is admitted.</p> <p>Access to Māori support and advocacy services is available via family members of residents and from Kuia and Kaumatua from the local iwi as well as from the District Health Board.</p> <p>Care staff interviewed confirm an understanding of cultural safety in relation to care and that processes are in place to ensure that residents who identify as Māori have access to appropriate services.</p> <p>Cultural safety education occurs.</p>
<p>Standard 1.1.6: Recognition And Respect</p>	FA	<p>Culturally safe practices are implemented and are being maintained, including respect for</p>

<p>Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>residents' cultural and spiritual values and beliefs. Staff can describe processes on how to access interpreters.</p> <p>Residents interviewed confirm their culture, values and beliefs are being respected, and their spiritual needs are met. Church services are held on site on a regular basis as part of the activities programme.</p> <p>Care staff interviewed confirm an understanding of cultural safety in relation to care, and that processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Expected staff practice is specified in their employment agreement and job descriptions. Residents and family interviewed report that staff maintain appropriate professional boundaries. Care staff interviewed demonstrate an awareness of the importance of maintaining boundaries and processes to which they are required to adhere.</p> <p>There are policies and procedures in place that outline the safeguards to protect residents from abuse and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies reviewed include complaints policies and procedures and house rules which include information on conflicts of interest including the accepting of gifts and personal transactions with residents and are reviewed.</p> <p>A review of the accident/incident reporting system, complaints register and interviews of the facility manager indicates that if there are any concerns around resident care, then these are investigated with appropriate management of any incident put in place.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. The clinical manager, the registered nurse and the facility manager are committed to ensuring that service provision is based on best practice, including access to clinical nurse specialists and district health board specialists. The policies in use include references to evidence-based research.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>An open disclosure policy and associated procedure is in place to ensure staff maintain open communication with residents and their families. Residents' files reviewed provide evidence that communication with family members is being documented in residents' records.</p>

<p>environment conducive to effective communication.</p>		<p>Incident forms record evidence of communication with the family following adverse events with this also documented on the communication record in each resident file and in the progress notes.</p> <p>Residents and family members interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.</p> <p>The facility manager and registered nurse are able to describe access to interpreting services.</p> <p>The residents and family are informed of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>Residents are provided with an information pack when they ask about the service and on entry to the service. Information about the dementia unit is verbally provided to potential residents and family.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ohope Beach Care Limited is the governing body and is responsible for the services provided at Ohope Beach Rest Home. It maintains the following agreements for the provision of publicly funded services: Aged Related Residential Care Services and an Adult Package of Care agreement with the Bay of Plenty DHB. The service also provides Carer Support which is funded by the DHB on an individual basis.</p> <p>There is a documented annual business plan in place which includes the direction, vision, mission statement, scope of services, objectives and an action plan. The business plan is developed by the owner in consultation with the management team who are the facility manager, the clinical manager and the registered nurse.</p> <p>The facility manager provides an update on the business plan through monthly reporting to the director.</p> <p>Ohope Beach Rest Home is managed by a non-clinical facility manager who was appointed to this position in July 2006. The facility manager is an emergency medical technician, has a national certificate in business (first line management) level 4 and are an assessor for Careerforce to level 4.</p> <p>The clinical manager has responsibility for oversight of the clinical care provided and reports to the facility manager. The clinical manager was appointed to the role in February 2016. The clinical manager is a registered nurse who has previously owned and operated a rest home. They is supported by another registered nurse who has experience in acute care settings and has been employed in the role since November 2015. Both the clinical manager and</p>

		<p>registered nurse have training relevant to aged care and have completed InterRAI training. Both have completed at least 8 hours of professional development in the previous year.</p> <p>Ohope Beach Rest Home can provide care for up to 36 residents (11 rest home and 25 dementia beds available). Occupancy on the day of the audit was 32 residents (10 rest home and 22 dementia). The DHB has agreed in writing that the dementia unit can accommodate up to 27 residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>There are systems in place to ensure the day-to-day operation of the service continues if the facility manager is absent. In this situation the facility manager's position would be managed by the administrator in collaboration with the clinical manager. If the absence was for an extended period, then the director would make alternative arrangements.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a documented quality plan which is reviewed annually. Risk management is incorporated within the annual business plan.</p> <p>The service implements organisational policies and procedures to support service delivery and purchases the framework of all policies, associated procedures and forms from an external consultant who was engaged in April 2016 and the system was implemented in June 2016. The previous system was archived. New policies and procedures reference InterRAI and pressure injury management.</p> <p>There is a formal document control process in place. Documents are reviewed two yearly or earlier when required.</p> <p>The quality and risk management systems include quality improvements, risk and hazard management, resident satisfaction including complaints management, incidents and accidents, health and safety, infection prevention and control and restraint management. Quality improvement data is collected by the clinical manager who analyses the data and evaluates the findings. Results are communicated to staff at the two-monthly quality meeting and the two-monthly staff meetings. An internal audit programme is implemented with corrective action plans documented. Corrective actions are documented following internal audits or the patient satisfaction survey on a corrective action form. Corrective actions are also identified following investigations of incidents and accidents and complaints.</p> <p>There are two monthly resident meetings and a family meeting is held annually for all families.</p>

		<p>There is an annual family and resident satisfaction survey which precedes the family meeting. Results of the satisfaction survey conducted in 2016 show satisfaction with services received.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. These have been revised since the change in legislation. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. There are two health and safety representatives representing staff. Health and safety matters are discussed at the quality meeting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The facility manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. External authorities have been advised of any serious incident if these have occurred.</p> <p>Staff document adverse, unplanned, or untoward events to identify opportunities to improve service delivery, and to identify and manage risk. A review of incidents and accidents for the month of September 2016 was conducted. These were well documented and comprehensively analysed and reported.</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>There are policies and procedures in relation to human resources management. Reviews of staff records were conducted. Each record contained recruitment documentation, references, police vetting, an employment agreement, a job description, evidence of qualifications, orientation records, evidence of annual performance appraisals.</p> <p>Professional qualifications are checked by the facility manager when due.</p> <p>There are rosters in place. Rostering meets and exceeds minimum staffing requirements.</p> <p>Both registered nurses are approved InterRAI assessors and are aware of the need to meet their annual obligations for maintaining competency</p> <p>Staff are provided with performance appraisals annually or earlier if required.</p> <p>The facility manager is responsible for management of the in-service education programme which includes mandatory monthly training. Attendance is recorded.</p> <p>Caregivers included in the sample of records reviewed had completed the dementia unit standards. All caregivers except for one provide care to residents in the dementia unit and the rest home.</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>The service has a staffing levels and skill mix policy. The registered nurses are on site seven days a week during the day or on call if not on site after hours. One registered nurse lives on site and is able to be called at any time if required. There are three caregivers rostered on duty over night with one in the rest home and two in the dementia unit. Care staff interviewed report there is adequate staff rostered. Residents and family state that there are sufficient staff to support them or their family member.</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>Resident information is entered in an accurate and timely manner into an electronic register. Records include both electronic and paper-based records. InterRAI information is recorded accurately in the InterRAI software programme. Staff enter resident's data into an electronic spreadsheet on the day of admission to the facility.</p> <p>Residents' information is held securely. Information is not on public display.</p> <p>Records reviewed were legible. Clinical records are recorded appropriately. Historical records are held on site and accessible.</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 residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner as described by residents interviewed. Information packs are provided for families and residents to the rest home and the dementia unit, prior to admission. The facility requires all residents to have a needs assessment completed prior to entry with the completed using an interRAI assessment. All resident files reviewed included confirmation of the level of care required prior to the resident entering the service.</p> <p>Interviews confirm that the registered nurse or the clinical manager admits new residents into the facility with input from the facility manager. The registered nurse receives hand-over from the needs assessment service and other health providers if involved such as a handover if the resident is transferred from another facility, and utilises this information in the development of the care plan for the resident. Families are encouraged to be a part of the admission and entry process with this confirmed by family interviewed.</p> <p>The mental health service for older people were present on the day of audit to assess a resident currently using dementia care to establish if they should be transferred to a different level of care at another facility at the family request. The request for review of the resident had been responded to promptly, that is, within a week.</p>

		<p>Clients entering or enquiring about the dementia unit have a specific information sheet that lets them know what to expect.</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>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge, or transfer of residents are undertaken in a timely and safe manner. The clinical manager reports that they include copies of the resident's records including: general practitioner visits; medication charts; current long term care plans; upcoming hospital appointments; and other medical alerts, when a resident is transferred to another health provider.</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>	FA	<p>Medicine management policies and procedures are in place and implemented, including processes for safe and appropriate prescribing, dispensing and administration of medicines. Standing orders are documented as per Ministry of Health guidelines with annual review completed. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner.</p> <p>Medicine charts list all medications the resident is taking, including name, dose, frequency and route to be given. All entries are dated and allergies recorded. All residents have photo identification with confirmation that the photograph is a true likeness. Discontinued medicines are identified. The three monthly general practitioner reviews are all completed within the three-monthly timeframe or more frequently as required. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily.</p> <p>Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Unwanted or expired medications are returned to the pharmacy with the pharmacist and staff signing for returned and new medication. Medication administration was observed during lunch time in the rest home and the dementia unit. The staff members checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines, and then signed off after the resident took the medicines.</p> <p>Staff are authorised to administer medications with competencies completed annually.</p> <p>There is a resident who self-administers medicines with a competency completed to determine that they are able to self-administer medications safely. The resident is confirmed as having a safe secure place to store medications if they self-administer.</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>The food service policies and procedures are appropriate to the service setting, with seasonal menus reviewed by a dietitian last in 2015. Residents' dietary profiles are developed on admission with a current list of likes, dislikes and allergies maintained as part of the six monthly review of care plans. These are updated also as changes occur. Interviews with kitchen staff confirm their awareness of the residents' dietary requirements.</p> <p>Kitchen staff are trained in safe food handling processes with certificates displayed in the kitchen. Food safety procedures are adhered to.</p> <p>Residents who require special dining aids are provided for, to promote independence. The residents' files demonstrated monthly monitoring of individual resident's weight with any weight loss reported and measurement of weight increased to weekly. Supplements are provided to residents with identified weight loss.</p> <p>Residents state they are satisfied with the food service and family for residents in the dementia unit state that they are happy with meals and service provided. Residents report their individual preferences are met and adequate food and fluids are provided. Food on the days of audit was hot and met assessed resident needs. The service provides additional food over a 24-hour period for residents with dementia and for others in the service if they require snacks outside of meals and morning/afternoon tea times.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</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>The clinical manager records any requests for information around entry to the service. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services. The service has a documented process for the management of declining resident's entry into their care.</p> <p>The scope of services provided is identified in the needs assessment and communicated to prospective residents and their families. The clinical manager assesses the suitability of residents with support and input from the facility manager.</p> <p>When residents are not suitable for placement at the service, the family and / or the resident are referred to other services, depending on their level of needs with the needs assessment and coordination service informed.</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>FA</p>	<p>The registered nurse or the clinical leader completes an interRAI assessment and a variety of risk assessment tools on admission and as required. The files of all new residents confirm that the interRAI assessment is completed within three weeks of entry to ensure that this is used as the basis of care planning. All resident files reviewed include a current interRAI assessment with these completed in a timely manner.</p> <p>A medical assessment is completed by the general practitioner and recreational assessment completed by the activities coordinator. Baseline recordings are recorded for weight management and vital signs.</p> <p>The needs, support requirements, and preferences are collected and recorded for all residents with the interRAI assessments aligning with the documentation of the long term care plan.</p> <p>Staff interviews confirm that the families are involved in the assessment and review processes with family signing on the assessment and/or care plan to indicate their involvement. Family were observed to be asked on the day of the audit to review the care plan and identify any extra cares/support required. They were asked to bring their experience of strategies that have worked in the past to manage challenging behaviour.</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>FA</p>	<p>The care plans are resident focused and describe in depth strategies for goals for residents in the rest home and in the dementia unit. The residents' files have sections for the resident's profile, details, observations, care plans, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals are realistic, achievable and clearly documented. The service records interventions for the achievement of the goals.</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>FA</p>	<p>Residents' state that they receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the care plan documented for each individual resident. Residents' files reflect residents and family involvement in the development of goals and review of care plans.</p> <p>Interview with the general practitioner confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as discussions with the needs assessment service coordinators (NASC), podiatrist and mental health services for the older adult.</p> <p>Wound management for one resident was reviewed. Documentation includes a comprehensive</p>

		<p>assessment, plan, progress notes and review of the overall progress completed one to two weekly. Photographs are used to document progress.</p> <p>The 24-hour activity plan and the care plan document interventions and strategies to manage any behaviours that challenge.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programmes are planned for each area (rest home and dementia unit) and reflect the needs and abilities of the different residents. The programmes confirm that independence is encouraged and choices are offered to residents. The activities coordinator is training to be a diversional therapist and they develop and implement the activity programmes with support and oversight from a diversional therapist from another facility. The activities coordinator works five days a week with time recently adjusted to work in the dementia unit between the hours of three and five or six in the afternoon to support residents who have difficulty settling and eating at this time.</p> <p>An activities plan is documented for each day/week/month and displayed in each area, that is, one for residents in the rest home and one in the dementia unit. A lot of focus for residents is the provision of individual activities as needs of the groups vary from day to day and between areas.</p> <p>Activities include: physical; mental; spiritual and social aspects of life, to improve and maintain residents' wellbeing. During the onsite audit, activities included: residents going for an outing; physical activities and one-on-one activities. Residents and family confirm they are satisfied with the activity programmes. One family member for example described how their family member was engaged despite their decline in abilities and their need to sleep more.</p> <p>On admission, the activities coordinator completes a recreation assessment for each resident. Each resident has an individualised plan with a monthly activity review completed and a daily log of attendance.</p> <p>Residents in the dementia unit have a 24-hour activity care plan documented that links to the long term care plan for managing challenging behaviours.</p> <p>New residents have assessments and plans completed in line with completion of the interRAI assessment (refer 1.3.8).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	PA Low	<p>There is a policy that outlines review of care plans and the link to interRAI. All residents have a current care plan however in the past there has been a lack of review of care plans. A plan is in</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>place to ensure that care plans are reviewed six monthly.</p> <p>There are frequent reviews completed by the general practitioner for each resident. All reviewed had the need for a three monthly medical review to be completed however each of the eight resident files reviewed indicated that the resident had been reviewed by a general practitioner at least one or two monthly with some who had deteriorated reviewed weekly or as required. A review of resident records indicates that the general practitioners respond in a timely manner when notified of any changes in a resident's condition (generally the next day). The general practitioner stated that staff are responsive to any changes in the resident condition and inform them in a timely manner.</p> <p>Progress notes are completed at every shift by the clinical team for residents in the rest home and dementia unit and any changes recorded as these occur. Progress notes reflect the response to interventions and treatments including any use of 'as required (PRN) medication. Residents are assisted in working towards goals. Short term care plans are developed for acute problems, for example: infections; wounds; and other short term conditions.</p> <p>Records reviewed indicate that staff respond quickly to any change in a resident's condition with appropriate authorities or referrals made.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The clinical manager stated that residents are supported in access or referral to other health and disability providers. The registered nurse or clinical manager manages referrals for residents to the GP; dietitian; physiotherapist and mental health services. The general practitioners confirmed involvement in the referral processes. The review of residents' files included evidence of recent external referrals to the wound and other specialists. The podiatrist visits monthly and each resident has access to a dentist. Some residents have dental treatment managed through the hospital system of through a local dentist. Retinal screening takes place for residents identified as having diabetes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are documented processes for the management of waste and hazardous substances in place. Policies and procedures provide guidance for staff. Material safety data sheets are available and are accessible for staff. A hazard register is available. Staff receive training and education on safe and appropriate handling of waste and hazardous substances, including chemical safety and education. Monthly visits are made by the chemical supplier representative who reviews cleaning and laundry processes. Sluice facilities are available for the disposal of waste and hazardous substances.</p>

		Protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled is provided. Staff were observed wearing protective clothing.
<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>A current building warrant of fitness is displayed which expires 11 October 2017. There have been no building modifications since the last audit. A grounds person is employed on a part time basis and maintenance staff and external contractors are employed as required. There is a planned maintenance schedule in place and a reactive maintenance system.</p> <p>Medical equipment is available which includes shower chairs; a hoist and sensor alarm mats. There is an annual test and tag programme for electrical equipment which is up to date. Checking and calibrating of clinical equipment occurs annually. Staff interviewed confirmed they have adequate access to equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are internal courtyards and grass areas with shade, seating and outdoor tables. The dementia unit is a secure unit with a garden and entry/exit points into the facility from the courtyard. Rest home residents have access to external areas.</p> <p>Hot water temperatures are recorded monthly and the records reviewed indicate they meet the standards for vulnerable residents.</p> <p>The facility owns a 12 seater van for transporting residents. The facility manager oversees the warrant and maintenance</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 requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilet and shower facilities available throughout the facility. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Rest home residents have access to a mix of communal toilets and showers or ensuite toilets and hand basins. One rest home room includes its own shower. The rooms in the dementia unit all have hand basins except for one room. The dementia residents use communal toilets and showers. There is a toilet for visitor use in the rest home area.</p>
<p>Standard 1.4.4: Personal Space/Bed</p>	FA	<p>With two exceptions, all bedrooms in the rest home area provide single accommodation. The two double bedrooms are currently used as single occupancy bedrooms. Bedrooms provide</p>

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>adequate personal space to allow residents and staff to move around within the room safely. Resident's bedrooms are personalised to varying degrees.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is adequate access for entertainment, relaxation and dining in both the rest home and dementia unit and there are external areas. Residents were observed moving freely within these areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.</p> <p>Laundry staff are responsible for management of the laundry and all linen is washed on site in the main laundry in the dementia unit. There is a second smaller laundry in the dementia unit that is used if the machines in the main laundry are full. There is a clean and dirty flow throughout the laundry. Laundry is done by dedicated laundry staff seven days a week. Chemicals are supplied by a commercial operator who supplies the dispensing system Chemicals are stored in the cleaner's cupboard and in the laundry.</p> <p>Cleaning staff are employed seven days a week. There is one cleaner on duty each day. The rest home staff assist the cleaner when able.</p> <p>The effectiveness of the cleaning and laundry services is monitored by staff and via the internal audit programme.</p>
<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 fire evacuation scheme was approved 05 June 2005. There are six monthly trial evacuations held.</p> <p>Documented systems are in place for essential, emergency and security services. All senior staff are required to complete first aid training. Emergency and security education is provided to staff during their orientation phase and at appropriate intervals. Staff confirm recent education on fire, emergency and security situations. Staff records sampled provides evidence of current training regarding fire, emergency and security education. Rosters reviewed indicate that there is always a staff member with first aid training on duty.</p>

		<p>Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'. Fire evacuations occur six monthly. Information in relation to emergency and security situations is readily available/displayed for service providers and residents. There is emergency equipment that is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Oxygen is maintained in a state of readiness for use in emergency situations. The service has emergency lighting, torches, gas and electric power to the site, extra food supplies, emergency water supply, blankets, and cell phones available in the event of an emergency. The site is situated next door to the fire station.</p> <p>The call bell system is electric. The indicator panel is in the dementia unit outside the nurses' station. The rest home staff carry walky-talkies which alert them if a bell is used. The calls are tested monthly by the maintenance person (records sighted).</p> <p>There is a security system in place. Staff lock the rest home in the evenings. There are CCTV cameras in corridors and both lounges in the rest home and dementia unit.</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>	FA	<p>Residents are provided with adequate natural light. Each bedroom has an external window that opens for ventilation. All windows have security stays. The dementia unit is ventilated by air-conditioning. The rest home is ventilated by opening doors and windows. The building is heated by heat pumps and electric wall heaters. Residents and relatives interviewed confirm the facilities are maintained at an appropriate temperature.</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>	FA	<p>The responsibility for infection control is defined and there are clear lines of accountability for infection control matters in the facility. The infection control committee is part of the quality and health and safety meeting. There are identified infection control champions who are part of the quality and health and safety meetings. They also take responsibility for completing the infection control audits annually and are a resource for other staff if they have concerns. The committee meets two monthly.</p> <p>There are monthly reports documented by the clinical manager with corrective actions put in place when needed. The corrective actions are discussed two monthly at the quality and health and safety meeting.</p> <p>There is an infection control programme that was last reviewed in September 2016.</p> <p>There have not been any outbreaks of infection since the last audit.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate human, physical, and information resources, to implement the infection control programme and meet the needs of the organisation. Hand hygiene signs are sighted around the facility to remind staff and residents of the importance of proper hand hygiene.</p> <p>The facility maintains regular in-service trainings for infection control, including standard precautions, personal protective equipment, cleaning, infectious diseases and hand hygiene.</p> <p>The service has an infection prevention and control manual developed by an external consultant that serves as a reference.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. The policies have been developed by an external consultant and all staff have signed to state that they have read and understood these. Policies and procedures have been reviewed in 2016.</p> <p>Staff interviewed are aware of the infection control policies and can describe best practice as documented in policy. Staff were observed to be implementing the policies.</p>
<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	<p>The organisation provides relevant education on infection control to all service providers, support staff, and residents. The infection control education is provided by either the clinical manager or external resource speakers. Residents interviewed were aware of the importance of hand washing. Staff members confirmed receiving infection control training and could explain the importance of hand washing in the prevention and control of infection. Training was last provided in August 2016.</p> <p>The infection control coordinator interviewed and staff records confirm that they have had infection control training in 2015 and the registered nurse has also had training in 2016 around communicable diseases.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>A restraint minimisation and safe practice policy has been newly developed by an external consultant with all staff having read and understood this. Staff interviewed, observations, and review of documentation, demonstrate that restraint is not used in the service. There is a focus instead, on continuing to minimise any use of restraint with other strategies put in place to</p>

		<p>manage behaviours that challenge. There are no enablers in the facility. The service has a documented system if restraint or an enabler is required to be used.</p> <p>An annual report (July 2016) around restraint and enabler use is documented. There is a restraint register that is able to record any residents if restraint is used. There are no residents using restraint in the rest home or dementia unit. The restraint coordinator is the clinical manager.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Three of the six care plans required a six monthly review however this had not been completed in a timely manner. Three other files reviewed were for new residents. All residents had a current care plan documented relevant to the resident’s identified needs. The clinical manager and the registered nurse have worked to ensure that all documentation now meets policy expectations. There is a spreadsheet developed that outlines when reviews are due with a plan explained by both the clinical manager and registered nurse around how the timeframes will be met. The review of the activities plan for each resident does not always match the timeframe of completion of the care plan however the plan for review in the future includes review of the activities plan that will occur at the same time as the review of the care plan. This is already in place for new residents.	Three of the six care plans reviewed did not have a care plan that was reviewed six monthly with the activities plan reviewed at the same time as the interRAI and review of the care plan occurs.	Ensure that all care plans are reviewed six monthly with the review of the activities plan included as per the plan outlined.

				180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.