# Kyber Health Care Limited - Waikiwi Garden Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Kyber Health Care Limited

**Premises audited:** Waikiwi Gardens Rest Home

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

**Dates of audit:** Start date: 13 December 2016 End date: 14 December 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 38

# 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.

## General overview of the audit

Waikiwi Gardens is certified to provide rest home level care for up to 42 residents. On the day of the audit there were 38 residents.

The experienced owner/manager is supported by an administration manager and two registered nurses. Residents and family interviewed were complimentary of the service they receive.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. The prospective owners were interviewed by telephone on the first day of the audit.

This audit identified that an improvement is required around staff and management meetings, staff training, registered nurse review of residents, timeliness of assessments, weight management, evaluations, medication management, cleanliness in the kitchen, areas of carpet and infection control surveillance.

## Consumer rights

Waikiwi Gardens Rest Home provides care in a way that focuses on the individual resident. The service identifies the residents’ personal needs, culture, values and beliefs at the time of admission. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

Waikiwi Gardens Rest Home is implementing a quality and risk management system that supports the provision of clinical care. Policies and procedures are maintained by an external quality advisor who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints and internal audits surveys. The health and safety programme meets current legislative requirements. There are human resources policies including recruitment, job descriptions, selection and orientation. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an annual education/training schedule. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

There is a comprehensive admission package. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whanau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Staff that are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed were reviewed at least three monthly.

Two activity co-ordinators oversee the activity programme for the residents. The programme runs during the day and the evening over six days each week. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences.

All meals and baking are done on site. Residents' food preferences, dietary and cultural requirements are identified at admission and in an ongoing manner and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. There is safe access to the communal areas and outdoor seating and shade. Resident bedrooms are personalised. There are adequate communal shower/toilet facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

A civil defence/emergency plan is documented for the service. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit no residents were using restraints and one resident was using an enabler.

## Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Relevant infection control education is provided to all service providers as part of their orientation and as part of the on-going in-service education programme. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 36 | 0 | 6 | 3 | 0 | 0 |
| **Criteria** | 0 | 83 | 0 | 7 | 3 | 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 Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. Staff interviewed (one owner/manager, one administrator, two registered nurses (RN), three caregivers and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service.  Interview with the prospective owners confirmed their understanding of the consumer rights and their obligations to ensure the Code of Health and Disability Services Consumers’ Rights and the Nationwide Health and Disability Advocacy Service information is clearly displayed and easily accessible to anyone to whom the information is relevant to. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents including photographs were obtained on admission and sighted in seven of seven resident files reviewed (including one resident on younger persons with disabilities contract). Advance directives where sighted in each residents file relating to resuscitation status, having been completed by the resident (where they were competent to do so) in the presence of the general practitioner. Policy dictates that where a resident is not competent to make an advance direction around resuscitation, resuscitation will be provided.  An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  Seven admission agreements reviewed had been signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Nationwide Health and Disability Advocacy Service brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice which aligns with Right 10 of the Code. The administrator leads the investigation of any concerns/complaints in consultation with the RN for clinical concerns/complaints. Complaints forms are visible throughout the facility. A complaints procedure is provided to residents within the information pack at entry. A complaints register is maintained. There has been one complaint made since the last audit. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainant. Corrective actions were implemented and followed up.  Residents and families interviewed are aware of the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The owner/manager or RN discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. Six residents and two family members interviewed reported that the residents’ rights were being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. Three caregivers interviewed reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents’ privacy is respected. Guidelines on abuse and neglect are documented in policy. There were three double bedrooms that all had privacy curtains installed. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. The service has access to a cultural advisor from the local Iwi Health Authority. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents’ care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the caregivers confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility fortnightly or more often if required. Resident/family meetings are held monthly and are led by the administrator. Residents and family/whānau interviewed reported that they are satisfied with the services received. A resident satisfaction survey is completed annually. The prospective owners stated that they will continue with best practice at Waikiwi Gardens Rest Home. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Ten incident forms reviewed for November 2016 identified family were notified following a resident incident. The owner/manager and RN confirm family are kept informed. Family members interviewed confirm they are notified of any incidents/accidents. Families receive regular newsletters and are invited to attend the monthly resident/family meetings. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waikiwi Gardens Rest Home provides care for up to 42 rest home level residents. On the days of audit there were 36 residents, including two persons less than 65 years on individual contracts through Accessibility. All other residents are under the ARCC. There were four independent boarders living within the rest home who are independent and do not receive care services.  The facility is currently being managed by one of the owner/directors (non-clinical) who is on site 40 hours per week. She is supported by a non-clinical administrator who coordinates and oversees quality activities and human resource management. The administrator attends the service fortnightly. Two full-time registered nurses (RN) are responsible for clinical management and overseeing the clinical service. The manager has completed at least eight hours of professional development including attending a health and safety compliance workshop in August 2016.  The prospective owners currently own a certified residential disability care facility and have owned this facility since April 2015. The facility provides care and residence for intellectually disabled residents. They have researched and have a broad understanding of the requirements of the ARC contract. There has been a transition plan developed in consultation with the current owners that will allow for a seamless transition for residents and staff. During that time the prospective owners will be introduced to relevant personnel within the DHB and community. The current registered nurses will continue and the current owner will be on site for at least a two week transition period and available as required after this to assist the prospective owners to transition from managing a disability service to an aged care service.  The prospective owners have clearly documented; the purpose, values, scope, direction, and goals of the organisation and ensure that the purpose, values, scope, direction and goals will be regularly reviewed. The prospective owners will be taking on owner/operator roles, support will be provided by the owner/manager for a mutually agreed timeframe. A position description for the prospective owner/manager has been developed and includes that the manager will be on site 40 hours per week and on call and all appropriate requirements for the service including efficient and effective management of the day to day operation of the service and the provision of timely, appropriate and safe services to residents. The tentative settlement date is late January/early February 2017. Relevant authorities have been notified of pending change of ownership. |
| 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 | Interview with the prospective owners and current management, informed that there will be no changes to the day to day operation of the facility. The two full-time RNs will continue to provide afterhours clinical cover and one of the nurses will provide a temporary management role in the event of the owner/manager being away (confirmed in interview with the registered nurses). The prospective owners will live in the area and will be available to the staff 24 hours, seven days a week. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Waikiwi Gardens Rest Home has a quality and risk programme that is being implemented and includes quality goals for 2016, for example around service delivery and staff management. Policies and procedures are maintained by a recognised aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements. Staff confirmed they are made aware of any new/reviewed policies. There are monthly staff and management meetings scheduled with the first meetings commencing in August 2016. These have not occurred monthly as planned. The meeting minutes that were available identified quality data as being discussed including infections, accidents and incidents, health and safety, concerns/complaints and internal audits. Staff are required to read and sign the quality data information which is generated on a monthly basis.  There is a 2016 internal audit programme that covers all aspects of the service including environmental, food service, cleaning service, resident care and documentation. Corrective actions for partial compliance had been developed, implemented and signed off by the administrator. The administrator advises there has been a reluctance of relatives/residents to participate in the 2016 annual survey. Of three surveys sent to willing participants, one was returned with positive comments. A six week post admission survey is included in the admission pack with three returns to date (reviewed) with no corrective actions required. Resident meetings are monthly and provide residents with a forum for feedback on the services. The administrator chairs the resident meetings.  A health and safety committee has been formed with representatives such as maintenance, cleaning and caregivers. The maintenance person is the health and safety officer and coordinates the committee meetings. The owner/manager and administrator attended a health and safety compliance workshop in August 2016. There is a current hazard register. Staff interview confirms they are kept informed on health and safety matters at meetings. There is a falls prevention and management policy in place and falls are addressed on an individual basis as part of the care planning process. A 24-hour clock is completed each month to analyse time and location of falls and other incidents such as challenging behaviours. Corrective actions are identified and implemented where appropriate.  Interview with the prospective owners confirmed the current quality management system and performance monitoring programme will continue following the sale. The owner/manager and administrator will help mentor the prospective owners to the quality risk system during the transition period. There are no planned changes to the current policies and procedures. |
| 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 | There is an incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms (four unwitnessed falls, four witnessed falls, one medication error and one other) for the month of November 2016 were reviewed. All document timely RN review and follow-up. There is documented evidence the family had been notified of incidents/incidents. The service collects incident and accident data and analyses falls according to time and location of fall. Monthly collation includes graphs and trend analysis.  There has been three medication incidents documented in 2016 year to date. All medication errors have been documented and managed appropriately. Medication procedure has been audited as part of the internal audit programme by a health professional (pharmacist). Discussions with the owner/manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. The service has a process/policy that reflects the Health and Disability Services (Safety) Act 2001 section 31 reporting guidelines. |
| 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. | PA Low | There are human resources policies to support recruitment practices. Five staff files sampled (one RN, three caregivers and one activities coordinator) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the RNs. The two RNs have completed InterRAI training. All staff have a current first aid certificate.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Staff complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. However food safety and pressure injury prevention training has not been completed. The RNs and caregivers complete an annual medication competency and attended medication education in October 2016 provided by the pharmacist. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are always two care staff on duty 24 hours a day, seven days a week. The owner/manager works on and off-site and is readily available to staff. Two full-time RNs cover seven days a week and are available on call afterhours. The RNs share the on-call duties. Caregivers interviewed confirmed the RNs are readily available after hours. The residents interviewed inform there are sufficient staff on duty at all times. The rosters sighted confirmed that staff are replaced on the roster. Four hours per day is dedicated to cleaning duties and carried out by a staff member allocated to cleaning duties.  The prospective owners stated in the interview that there is no intention for them to make any changes to staff that will transfer over to the new owners on the date of settlement. The prospective owners will be taking on the day to day management, organisational management and governance of the facility from the current owner/manager. They have experience managing staff in care facilities, including staff skill mix and contractual obligations. The prospective owners will also be available to the staff 24 hours, seven days a week. |
| 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 are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area. |
| 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 | Residents’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs including information on the services provided for resident and families. Admission agreements for long term residents aligned with contractual requirements. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The yellow envelope transfer system used ensures all relevant documentation is made available to the receiving provider. The residents and their families are involved for all exit or discharges to and from the service. |
| 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 Moderate | There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Medications received (blister packs) are checked on delivery by both registered nurses. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored weekly.  Eight of twelve medication charts reviewed met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. Administration records demonstrated that not all medications are signed as administered and one medication that was not currently charted (due to a charting error) was being administered. Medication errors were documented on incident forms and investigated with competencies of staff being reviewed where appropriate. The internal auditing programme includes medication audits completed by registered nurses.  Policies for controlled medications document a safe practice that includes two medication competent staff signing for medications, one being a registered nurse when a registered nurse is on duty. There were no regular controlled drugs in use and very infrequent use of as required controlled drugs. A registered nurse at been on duty each time these were administered for the last four months. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | All meals at Waikiwi Gardens are prepared and cooked on site by a recently employed cook who has not worked in the area of food preparation for many years and a second cook for her days off. Neither have completed food safety education (link 1.2.7.5). There is a four weekly seasonal menu which had been reviewed by a dietitian in February 2014. Food preferences are met and staff can access the kitchen at any time to prepare a snack if a resident is hungry. The cook receives a dietary profile of resident dietary requirements and any likes or dislikes including updates. Special diets including modified foods are provided although only diabetic diets were required at the time of the audit. .  Staff were observed assisting residents with their meals and drinks in the main dining room.  Fridge, freezer and end cooked temperatures are monitored weekly. A kitchen cleaning schedule was not documented and cleaning was not of an acceptable standard. Cleaning was addressed on the day. Chemicals are stored safely within the kitchen.  Resident meetings along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes. |
| 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 | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whanau as appropriate if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an initial assessment on admission (link 1.3.3.3) including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission (for new admissions – see 1.3.3.3) and six monthly, or earlier due to health changes. Resident needs and supports are identified through the on-going assessment process in consultation with significant others. InterRAI assessments, assessment notes and summaries were in place for all residents’ files sampled that had been at the service for longer than 21 days. Long-term care plans in place reflected the outcome of the assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident files reviewed were resident focused and individualised. Identified support needs as assessed were included in the care plans for all resident’s files. Files sampled included individualised preferences relating to personal hygiene needs including shower times and days. Files sampled included a resident with seizures, an insulin dependent diabetic and a resident with high falls risk as requested by the DHB. There were no residents at the facility who wandered and incident form review did not identify any recent incidents of wandering. Care plans evidenced resident (as appropriate) and family/whanau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process.  Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as the physiotherapist and mental health services. Short term care plans were in place for short term needs. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families were documented in the resident’s progress notes.  Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Initial wound assessments and on-going evaluations were in place for one resident with a surgical wound. There was a range of equipment readily available to minimise pressure injury. There is access to a wound nurse specialist at the DHB as required.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.  Short-term care plans document appropriate interventions to manage short-term changes in health such as infections.  Monitoring forms are used for example observations, behaviour, blood sugar levels and neurological signs.  Care plans documented residents current needs, excluding one resident with recent significant weight loss. A second resident with a vulnerable nutritional status was unable to be accurately weighed. |
| Standard 1.3.7: Planned Activities  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. | FA | There are two activities coordinators who work a total of 60 hours per week and provide an activities programme over six days that incorporates several evenings per week. Both activity staff has current first aid certificates. There is an activity plan that meets the group and individual preferences of the resident group. Activities take place in the main lounge and in the smaller lounge for quieter one-on-one activities for more dependant residents. The programme is varied and interesting with board games, quizzes, reading, bowls, exercises, scrapbooking and pampering. There are van outings most days and often in the evenings. Links with the community involve visiting kindergartens, visiting community choirs, music entertainers and church services. A social history and activity plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed monthly. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | All initial care plans reviewed were evaluated by an RN within three weeks of admission. In all files sampled the long-term care plans have been reviewed at least six monthly or earlier for any health changes. However, the most recent review did not document progress toward goals in five of seven files sampled. The GP reviews the residents at least three monthly or earlier if required. On-going nursing evaluations occur as indicated and are documented within the progress notes.  Files reviewed demonstrated that short term needs were documented on short term care plans which were regularly evaluated. |
| 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 | Referral to other health and disability services was evident in the resident files sampled (link tracer 1.3.3). The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.  There are documented policies and procedures in relation to exit, transfer or transition of residents. The on call policy ensures there is a registered nurse on call at all times. Except in emergencies registered nurses determine transfer to hospital (often in consultation with the GP). Resident files and interviews confirmed this occurs. The residents and the families are kept informed of the referrals made by the service. |
| 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 are in place to ensure incidents are reported in a timely manner. Safety data sheets and product sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in a locked chemical cupboard. There are chemical spills kits located throughout the facility which are easily accessible. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current building warrant of fitness that expires 1 February 2017.  The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Carpet in two hallways has stretched and is no longer safe. Monthly inspections include call bell testing, monthly fire checks and hot water temperature monitoring. Hot water temperature recordings reviewed were below 45 degrees Celsius. Essential contractors are available 24 hours. Electrical testing and tagging was current and annual calibration and functional checks of medical equipment is completed by an external contractor. The hoist has been removed to an area that cannot be accessed by staff until the planned functional and electrical test occurs in February 2017. The hoist had not been used for many months and no residents require this.  The facility has corridors with sufficient space for residents to safely mobilise using mobility aids. The building is two levels. The upstairs level is reserved for residents who are able to manage the stairs independently (currently four of the seven rooms upstairs are occupied by independent boarders).  There is safe access the outdoor areas. Seating and shade is provided. There is a designated outdoor smoking area.  The RNs and caregivers interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including hoists and pressure injury prevention equipment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are adequate numbers of communal toilet and shower facilities for each wing. The toilets and showers are of an appropriate design to meet the needs of the residents. Communal toilet facilities have a system that indicates if it is engaged or vacant. |
| 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 are 36 single rooms and 3 double rooms. One double room was vacant during the audit, one was occupied by a married couple and one was occupied by two long standing close friends. Privacy curtains were in place. Residents and families are encouraged to personalize their rooms. Bedrooms viewed were personalized. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include a large main lounge and dining room and smaller lounges for small group and one-on-one activities and quitter seating. There is also a large activities room and a large conservatory/ sun room off the main lounge. Seating and space in the main lounge is arranged to allow both individual and group activities to occur. The communal areas are easily accessible for residents or with staff assistance. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures for the safe and efficient use of laundry services. There are dedicated cleaning staff five days a week who fully implement cleaning schedules. These and caregivers cover the laundry tasks. All linen and personal clothing is laundered on-site. The laundry is well equipped and well ventilated. Internal audits monitor the effectiveness of the cleaning and laundry processes. The cleaner’s trolley is kept in designated locked areas when not in use. There is a sluice room with personal protective equipment readily available. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A civil defence/emergency plan is documented for the service and was last reviewed in August 2013. The New Zealand Fire Service approved the fire evacuation scheme on the 22 February 2002. Fire drills occur every six months (last fire drill occurred in September 2016). Emergency management training occurs as part of orientation for new staff. Staff interviewed confirmed their understanding of emergency procedures. A gas BBQ is available for alternate cooking. Battery operated emergency lighting, extra torches and gas cooking is in use/available. There are adequate supplies available in the event of a civil defence emergency of food, water and blankets. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. Staff conduct security checks in the evenings to ensure the facility is secure. |
| 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 adequate natural light and safe ventilation. The environment is maintained at a comfortable temperature within bedrooms and communal areas. There are sufficient doors and opening windows for ventilation. All bedrooms have windows, which allow for plenty of natural light. |
| Standard 3.1: Infection control management  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. | FA | A registered nurse is the infection control coordinator and has a job description that outlines the responsibility of the role. The infection control coordinator provides monthly reports to management. The infection control programme has been reviewed annually.  Visitors are asked not to visit if they are unwell. Hand sanitizers were appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has attended an infection control study day at the DHB (April 2016). There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator has access to the infection control nurse specialist at the DHB, laboratory technician, GPs and public health. |
| Standard 3.3: Policies and procedures  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. | FA | There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been developed and reviewed by an external consultant and the content of policies reflected current good practice. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection prevention and control education is included in the staff orientation and is included in the infection control calendar. Resident education occurs as part of daily cares as appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance of infections that require antibiotics to determine infection control activities and education needs in the facility. Individual infection reports and short term care plans are completed for all infections. A monthly surveillance report includes number of infections by type, trends identified and any corrective actions required. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at staff meetings (link 1.2.3.6). Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and review the use of antibiotics.  There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. No residents were using restraints and one resident was using an enabler (a bed rail). Interview with the resident and documentation demonstrated that enabler use is voluntary.  Staff receive mandatory training around restraint minimisation. All care staff interviewed were able to describe the difference between an enabler and a restraint. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | There are monthly staff and management meetings scheduled with the first meetings commencing in August 2016. The meeting minutes reviewed evidenced quality data is discussed including infections, accidents and incidents, health and safety, staff training, concerns/complaints and internal audits. Staff are required to read and sign the quality data information which is generated on a monthly basis. However there was no documented evidence that all staff and management meetings were completed. | There is monthly staff and management meetings scheduled, with the first meetings commenced in August 2016. There was no documented evidence of staff meetings being completed for September and October 2016 and management meetings completed for September, October and November 2016 | Ensure that staff and management meetings are completed monthly as per the scheduled calendar.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an education planner in place that covers compulsory education requirements over a two-year period. However food safety and pressure injury prevention training has not been completed. Food safety training had not been completed as scheduled for the two cooks due to recent staff changes. The new cook has been scheduled to complete the training in early 2017; no set date had been confirmed as they are waiting for details of a suitable time when the course schedule is issued in February 2017. Pressure injury prevention training was scheduled for October 2016; however the training session was cancelled due to unavailability of the presenter. The pressure injury prevention training has been rescheduled for early 2017; no set date had been confirmed. | i) Food safety training has not been completed over a two-year period as scheduled for the two cooks responsible for the preparation and cooking of meals  ii) Pressure injury prevention training has not been completed over a two-year period as scheduled in October 2016. | i) Ensure the two cooks have attended food safety training  ii) Ensure all clinical staff attend pressure injury prevention education.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Twelve medication records reviewed demonstrated that general practitioners prescribe and review medications regularly. Indications for use for ‘as required’ medications were not always documented. The two medication rounds observed (by two different caregivers) demonstrated appropriate practice. However review of documentation demonstrated that medications prescribed are not always signed as administered and one medication that was not prescribed on the medication chart was being administered. A review of the GP notes and previous records indicated that this was an error made when the new chart was written. | (i) Four of twelve medication administration records sampled did not have all prescribed medications signed as administered.  (ii) One medication chart sampled had a ventolin inhaler being regular administer on an ‘as required’ basis that was not prescribed on the medication chart.  (iii) Four of seven medication charts sampled did not have indications for use for as required medications documented. | (i) Ensure that medications are administered as prescribed.  (ii) Ensure that only prescribed medications are administered.  (iii) Ensure that indications for use are documented for as required medications.  30 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The cook interviewed reported that night staff clean the floors and that regular weekly kitchen cleaning occurs. On the day of the audit cleaning was not of an acceptable standard. A second cook attended during the audit to begin some extra kitchen cleaning. | The cleanliness of kitchen was not at an acceptable standard. This was addressed on the day. A kitchen cleaning schedule is not documented. | Ensure that the kitchen is kept clean and hygienic and a system is developed to ensure that this is maintained.  60 days |
| Criterion 1.3.3.1  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. | PA Moderate | The registered nurses write in separate progress notes to the caregivers. Caregiver’s progress notes were brief and documented every shift. Registered nursing progress notes were detailed and described specific interventions or encounters. Registered nurses progress notes contained gaps of up to two months where no nursing interventions/reviews had been documented. | Seven of seven resident files sampled did not contain documented evidence of regular review by registered nurses. Progress notes had periods ranging from one to two months where no nursing interventions or assessments were documented. | Ensure that interventions, assessments and reviews by registered nurses are completed and documented regularly.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Each of the seven files sampled contained an initial assessment, an initial care plan, interRAI assessments and long term care plans. All files contained a current interRAI assessment where this was required (the younger resident did not require an interRAI assessment). Until recently only one of the two registered nurses was trained in interRAI assessments, due to difficulty accessing training and contractual timeframes were not always met. The second registered nurse completed interRAI training three months ago and since this time all timeframes have been met and all interRAI assessments have been bought up to date. As the issue has been addressed no finding has been made in relation to this. However other contractual timeframes were not always met.  All residents who were under the care of the house GP had contractual timeframes in relation to admission assessments met. Faxes sighted provided evidence that the doctors had been notified for residents who had chosen to retain their own GP’s but contractual timeframes had not always been adhered to. | (i) Two of the seven resident files sampled had not had the initial assessment completed within 24 hours of admission (noting that all were completed within 72 hours of admission).  (ii) Two of seven resident files sampled were not reviewed by a GP within two working days of admission where this was required. | Ensure that contractual timeframes around resident assessments are met.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Files, care plans, assessments and monitoring records demonstrated that resident’s needs were being met. One resident file demonstrated significant weight loss in the weight monitoring records. There was no evidence that this had been identified or managed. On interview the two registered nurses believed that with was a potential issue that related to the reliability of weights recorded. A second resident with a vulnerable nutritional status had documented fluctuations of up to 11 kg in two months. The registered nurses had identified this and noted that it related to mobility issues meaning the standing scales were not suitable to ascertain an accurate weight. | One resident with significant weight loss had not had this identified or managed and a second resident, at risk of mal nutrition was not able to be accurately weighed on the current standing scales. | (i) Ensure that weight loss is identified and managed.  (ii) Ensure that the scales are suitable to the resident group.  60 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 | A standard care plan review template document was used to evaluate resident care plan and these had been reviewed six monthly for all residents. Previous reviews documented progress to all identified goals in the care plans. However the most recent reviews in five files simply stated ‘reviewed and no changes required’ with a date and signature. | In five of seven files reviewed the most recent care plan evaluation did not document progress toward goals. | Ensure that care plan evaluations document progress toward desired outcomes.  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The maintenance person is proactive is addressing issues and completed planned maintenance. A recent planned extraordinary carpet cleaning involved a machine that stretched the carpet in two corridors so that it now poses a trip hazard. Other areas of the facility, both indoors and out are suitable and safe for residents. | The carpet in two corridors is stretched and rippled and poses a trip hazard. | Ensure the carpet does not pose a risk for residents.  90 days |
| Criterion 3.5.1  The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation. | PA Low | Current and up to date policies include a surveillance programme that includes all infections. However only infections requiring antimicrobial treatment have been included in the surveillance data. The data that is collected is analysed for trends and any trends addressed. | Infections that do not require antimicrobial use are not included in infection surveillance data. | Ensure all infections are included in infection control surveillance data.  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.