# Experion Care NZ Limited - Greendale Residential 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 Health Audit (NZ) 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:** Experion Care NZ Limited

**Premises audited:** Greendale Residential Care

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

**Dates of audit:** Start date: 26 January 2017 End date: 27 January 2017

**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:** 24

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Greendale Residential Care is an aged care facility owned by Experion Care NZ Limited. The service provides rest home level of care in a 24 room facility. There were 24 residents at the time of audit. The service has been through a recent change of management, with the current management team being in place for three weeks. The staff reported that they have seen improvements in the service delivery documentation under the new management team.

A certification audit was conducted against the relevant Health and Disability Services Standards and the service’s contract with the district health board. The audit process included an offsite stage one audit (document review) and onsite audit. The onsite audit included the review of resident and staff records, other documented information, observations and interviews. Interviews were conducted with management, clinical and non-clinical staff, residents, family/whanau and a general practitioner.

There are two high risk areas for improvement in consumer rights and providing a responsive complaint management process. There are two other moderate risk areas for improvements related to complaints management and consumer rights.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Residents and their families are informed of their rights at admission. Copies of the Code, posters and information relating to the Nationwide Health and Disability Advocacy Service are located throughout the facility.

The residents' cultural and spiritual values (including Maori) are assessed at admission to ensure they receive services that respect their individual values and beliefs. Interpreting services can be accessed as required.

Evidence-based practice is encouraged. The management team have demonstrated a commitment to promoting best practice and staff development.

Residents have access to visitors of their choice and are supported to access community services.

Consent and open disclosure was evident in residents' files reviewed. Any advance directives or end of life wishes are respected by the staff.

## 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. |

There is a documented business plan that records the organisation mission, values and philosophy. The plan is reviewed annually, with the progress toward achieving their goals monitored through the quality and risk systems. The quality systems include an internal auditing programme and collections and analysis of other quality data. When trends or shortfalls are identified in the internal audit or quality data, the service implements corrective actions to address the issues. The analysis and trends are reported to the owner/director and staff through a monthly report.

The new management team consists of two nurse managers who co-manage this facility and the other facility within the Experion Care NZ Limited. At the time of audit, one of the nurse managers is full time at Greendale. Both the nurse managers are suitably qualified and experienced to run aged care services. The nurse managers are also supported by an assistant manager/house manager, who is an enrolled nurse. The nurse managers’ report to the owner/director.

The policies and procedures are developed by an aged care consultant, then personalised to the service. The policies are current and have been reviewed by the management team.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the residents’ needs at the rest home level of care. The education programme for all staff is available and planned for the year.

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

## Continuum of service delivery

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

There are documented admission processes that require potential residents to be assessed as rest home level of care. If entry is declined, this is recorded and the refer is informed.

The nursing staff are responsible for the development of the care plans. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the residents and contractually requirements. There are planned activities that are meaningful to the residents, develop and maintain resident’s strengths skills, resources and interests. In interviews, residents expressed satisfaction with the activities programme.

A medication management system complies with legation and best practice guidelines for aged care. Medications are administered by care staff with current medication competencies.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. The kitchen was observed to be clean, tidy and meets food safety standards.

## Safe and appropriate environment

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

There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services.

There is a current building warrant of fitness displayed. There is a newly implemented maintenance system and programme that includes monitoring and upkeep of the building to meet the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for this environment.

All rooms have access to hand basins and shared or single ensuite toilets. There are adequate toilets, showers, and bathing facilities located through the facility that provide adequate privacy.

The environment is appropriate for rest home level of care services. The residents’ rooms and amenities provide physical privacy. There is sufficient space and amenities to facilitate independence.

The facility has an appropriate call system installed. There is access to a court yard and external areas for residents and their visitors. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

The service has a newly appointed maintenance worker and has developed a maintenance plan. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

## Restraint minimisation and safe practice

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

There are clear and comprehensive documented guidelines on the use of restraint, enabler use and challenging behaviours. There was no restraint use at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive education.

## Infection prevention and control

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

The infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating overseeing the infection control programme. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported to the owner/director and staff. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

## 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 | 0 | 0 | 2 | 0 |
| **Criteria** | 0 | 89 | 0 | 0 | 2 | 2 | 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 | Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Though the staff demonstrated knowledge of residents rights, there are areas for improvement to ensure these are respected at all times (refer to 1.1.3.6 and 1.1.3.7). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.  Three of the five residents interviewed reported that they are treated with respect and understand their rights. The relatives interviewed reported that residents are treated with respect and dignity. |
| 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 | The residents' files sampled had consent forms signed by the resident, or when appropriate, signed by the enduring power of attorney (EPOA). The files contained copies of any advance care planning and the resident’s wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families reported that they are provided with information regarding access to advocacy services. Families are encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is conducted as part of the in-service education programme. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA High | The complaints policy and the sampled complaints evidence that these were responded to and closed within time frames of Right 10 of the Code. Complaints forms are available at the entrance, with information given on the complaints process as part of the admission procedure and advocacy session with residents and families.  There are improvements required in the complaints management system, (refer to 1.1.13.1 and 1.1.13.3). |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interviews with the nurse manager and assistant manager). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is provided by the Nationwide Health and Disability Advocacy Service annually, with the brochures on display at the entrance.  At the time of audit is was observed that residents were addressed in a respectful manner and by their preferred names as was confirmed in interview with residents. |
| 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. | PA High | The privacy and dignity policy details how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting resident’s individual beliefs and values. All rooms are single occupancy rooms, which maintain physical, visual and auditory privacy. There are three rooms that can be double occupancy, though the assistant manager/house manager reported that these rooms have not been used as double rooms.  Improvements are required in ensuring residents wishes and rights are respected at all times (refer to 1.1.3.6 and 1.1.3.7). |
| 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 | There were residents who identified as Maori at the time of audit. The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable. The staff interviewed reported that they understand and have attended cultural training and demonstrated the importance of whanau to Maori residents. |
| 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 resident files sampled recorded the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to provide guidance on delivery of individualised support in a culturally and/or spiritually sensitive manner. Staff interviewed reported on the need to respect individual culture and values. The residents reported that cultural and religious beliefs are respected and reported there is access to church services if they wished to go. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The employment position description and the Code of Rights define residents’ rights relating to discrimination. Staff interviewed verbalised they would report any inappropriate behaviour to the nurse manager or assistant manager. The nurse manager reported they would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The planned yearly education programme sampled included sessions that cover good practice topics. There is specialist advice available if required. There is regular in-service education and staff access external education that is focused on aged care, dementia care and best practice. Staff reported that they were satisfied with the relevance of the education provided.  Policies and procedures are linked to evidence-based practice, there are regular visits by the GP and links with the local mental health services. Also refer to the corrective action at 1.1.3. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Documenting of open disclosure following incidents/accidents was evident. Families reported they are informed of any accident or incident.  Staff education has been provided related to appropriate communication methods. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service provides rest home level of care for 24 residents. There were three residents under the age of 65. The service does have several residents with mental health conditions, with staff being supported with ongoing education related to these specific diagnoses and the management of challenging behaviours. The care and support is planned to meet the needs of all the residents.  The mission, vision, values, philosophy and purpose are clearly shown in the organisational management policies. The strategic business plan (2016 to 2017) incorporates a review of the quality improvement plan. In addition to this plan there has also being an external review of the long term strategies of the service. The strategic business plan focus includes goals in the environment, communication, management, clinical, household, quality, health and safety and maintenance. The objectives are monitored through monthly quality data analysis. There are formal and informal communications with the owner/director by the management team (phone call transcripts and emails sighted) on progress to achieving goals.  The service is managed by two suitably qualified and experienced nurse managers who both co-manage the service and who are both registered nurses. The nurse managers have been in the role for under one month. The nurse managers have the responsibility for the overall management of the service and report to the owner/director. One of the nurse managers is currently full time at Greendale, with the other at the providers other Hawkes Bay facility. The nurse managers have each attended over eight hours’ education related to the management of aged care services. Both the nurse managers maintain professional development portfolios that maintain other related clinical education. The nurse managers’ report that their roles have not been finalised, and after an initial period of review, updating and implementing new policies and procedures, they will review their roles with the owner/director. The nurse mangers report the owner/director is responsive to making any required improvements. |
| 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 | The co-managers will fill in for each other during temporary absences. Greendale has an additional house manager/assistant manager (enrolled nurse) who provides support to management team. The nurse manager reports confidence in the management team to take on extended roles during temporary absences. The nurse managers’ reports there is an additional RN who is also available during their temporary absence. |
| 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. | FA | The staff and management demonstrate an understanding of the quality and risk processes that are identified in policy. The staff reported that they have seen improvements in the quality and risk management systems under the direction of the new management. Staff stated that quality improvement processes have been ‘communicated well” under the new management team and that they have a better understanding of quality and risk and the significance for gaining better outcomes in care and service delivery.  The services’ policies and procedures have been developed by an external aged care consultant. The new management team have reviewed and personalised the policies and procedures to the organisation’s needs. The policies and procedures are aligned with current good practice and service delivery and legislation requirements. Only current policies are available to staff, with previous documents archived.  The service has systems implemented for quality management, the collation and analysis of data, and processes to measure achievement against the quality and risk management plan and strategic directions. Monthly surveillance is collated and reviewed by the management team. Data is trended and results presented at operations meetings, staff meetings and presented to the owner/director.  When improvements are identified from the internal auditing system and review of quality data, corrective actions are recorded. These record the recommendation, actions required, who is responsible for implementation, the improvement or decrease since the last audit and if the actions implemented have resolved the issue. Meetings are used to review corrective actions put in place. The service has corrective action plans to address areas for improvement from their previous surveillance audit.  The service has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. |
| 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 | The management team and staff understand their responsibilities related to mandatory reporting and essential notifications. This includes responsibilities related to reporting of pressure injuries stage 3 and above.  The number of incidents are collated on a monthly basis. Samples of incident/accident forms and the trended data were reviewed. Any trends identified are notified and information fed back to staff and the owner/director. The service identifies strategies put in place in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident`s care plan as required. Actual and potential risks are identified and documented in the hazard register. Incident and accident information is shared with all staff and any corrective actions that have been taken are evaluated. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. Copies of APCs were sighted for all staff who require them.  Staff files provided evidence that appropriate processes are implemented for the recruitment, employment and orientation of new staff. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly described staff responsibilities. Staff complete an orientation/induction programme with specific competencies for their roles, such as medication management, as confirmed during staff files sampled. There are at least annual performance reviews for the staff sighted in the staff files sampled.  Education records sighted identify that staff education includes on-site planned education with topics that meet the contractual requirements. There are additional topics that cover the specific needs of the residents. Staff report there are a number of resident with mental health conditions, with the education programme having topics on this and the management of challenging behaviours. Attendance records are maintained. The nurse managers both are assessed as interRAI competent. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Rosters sampled evidenced that the skill mix and numbers meet contractual requirements and the residents' needs. All sick leave and annual leave is shown and replacement staff noted. All the care staff have current first aid qualifications. There is at least one staff member on duty at all times, with more staff during the business hours of the day. There is an on call roster for after-hours access to a RN.  There are sufficient numbers of kitchen housekeeping, activities, support and administration staff. |
| 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 sampled identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses’ station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member’s name and designation. The residents’ files sampled evidenced that all records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident’s hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to service policy includes all the required aspects on the management of enquiries and entry. Greendale Residential Care’s welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate and local communities and referral agencies. The admission agreement clearly outlines services provided as part of the agreement to entry. The signed admission agreements were sighted in all the files sampled. The residents and family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The standard transfer form notification from the district health board is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| 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. | FA | All medications files sampled showed they are reviewed as required and discontinued medications are signed and dated by the GP, allergies are documented, and photos present and three monthly reviews are completed. Medication charts are legibly written. The care giver who is competent to give medication was observed administering medication correctly. Medications and medication charts are stored safely and securely and medication reconciliation is conducted by the nursing staff when the resident is transferred back to service.  The service uses pharmacy packed sachets that are checked by the RN on delivery. The controlled drug register is current and correct. Weekly stock takes are conducted and all medications are stored appropriately. There were no residents self-administering medication at the time of the audit.  An annual medication competency is completed for all staff administering medications and medication training records were sighted. Refer to 1.1.3 were residents reported delays in receiving their prescribed medications. |
| 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. | FA | Meal services are prepared on site and served in the respective dining area. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. The resident’s weight is monitored regularly and supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. The satisfaction survey indicated that residents/family are happy with the meals provided. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The managers reported that a declined register was in place and when a resident is declined family/whanau are informed of the reason for this and made aware of other options or alternative services available. The resident is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews, the family/whanau expressed satisfaction with the support provided. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Life style care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate life style care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and life style care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to enough supplies. |
| 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 | The planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents.  The residents were observed to be participating in meaningful activities both inside and out in the grounds of the service. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the younger residents at the service. The residents and family/whanau reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident’s life style care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short term problem has resolved. |
| 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 | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP. |
| 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 | The cleaning, laundry and sluice room have safe, secure and appropriate storage of waste, chemicals and hazardous substances. The service has processes for the disposal of waste, which complies with local waste disposal and recycling requirements. There are contract arrangements for the management and disposal of sharps and any other clinical waste.  Personal protective equipment (PPE), such as gloves, disposable gowns and eye protection is available in the laundry/chemical storage area. The cleaning and care staff demonstrated knowledge on the safe use of the chemicals and PPE. Staff have ongoing education on infection prevention and control and the use of chemicals. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service has a current building warrant of fitness displayed.  Hot water temperatures are monitored with the recordings within safe guidelines. Medical equipment has been calibrated annually and electrical equipment is test and tagged. There has been a monthly compliance check of the environment.  The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to the external areas. There are covered seating areas off each of the lounge and dining areas.  The residents and families reported satisfaction with the environment. |
| 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 | The service has a mix of communal facilities and ensuites with toilets. There are adequate numbers of shower, bathing and toilet facilities throughout the service. All of the toilet and shower facilities have privacy locks and/or signage. The residents and families reported satisfaction with the facilities at the service. |
| 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 | All rooms are single occupancy and suited to the needs of residents requiring rest home level of care. There are three rooms that do have the capacity to be shared rooms, though it is reported that this has rarely occurred (where appropriate couples may share these rooms). The shared rooms do have the capability to have dividing curtains. Each resident’s room sighted had personal items of the resident and provides enough space for the resident to mobilise. The residents and families reported satisfaction with the personal space and the individualised care that meets the resident’s needs. |
| 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 | There is a central dining area and smaller lounge areas. Activities are conducted in one of the lounges, with one of the lounges a TV room and another a designed ‘quiet lounge”. Residents’ rooms and outside areas also provide areas for residents to relax or entertain. The residents and families reported satisfaction with the access to dining and lounge facilities. |
| 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 | The cleaning is conducted by specific household staff, with the caregivers assisting with the laundry duties. The laundry has a dirty to clean flow, with processes implemented for infection prevention and control. The laundry is a designated emergency egress and cannot be locked as the route through the laundry is part of the evacuation scheme. The service has developed processes to secure the chemicals in the laundry.  Chemicals, laundry and cleaning equipment are securely and hygienically stored in the cleaner’s room. The external chemical supplier conducts weekly site visits and provides reports on the effectiveness of the cleaning and laundry chemicals. The residents report overall satisfaction with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation scheme. The fire and emergency equipment has a monthly inspection as well as an annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted six monthly. Staff demonstrated knowledge on how to respond in emergency or civil defence situations. There is at least one staff member on duty each shift with the first aid qualification.  The service has gas for cooking and emergency lighting in the event of mains failure. There is drinking water that is accessible in emergency situations.  Each room, toilet and bathing facility has access to a call bell. The call bell system has a light, an audible alert and a display on central panels in each corridor when activated. The residents and families reported satisfaction with the time frames in which call bells are answered.  There are security processes at night were external windows and doors are locked. |
| 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 | All areas used by residents and families are ventilated and heated. Each resident’s room and hallway have wall mounted radiators and at least one window. The residents and family report satisfaction with the heating, light and ventilation. |
| 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 | Greendale Residential Care provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The registered nurse (nurse manager) is the infection control coordinator (ICC) and has access to external specialist advice from a GP, a specialist infection control advisory service and district health board infection control specialists when required.  The infection control programme is reviewed annually and is incorporated in the monthly meetings and review of the education programme is done. Staff are made aware of the infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. There are processes in place to isolate infectious residents when required.  A documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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 ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the infection control programme. Infection control reports are discussed at the management and monthly staff meetings, daily handovers and when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| 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 | Greendale Residential Care has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control standards that reflect current good practice. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. The ICC is responsible for monitoring and implementing the infection control programme. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Training is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets required legislative and current regulations. External contact resources included: GP; laboratories; specialist infection control advisory service and local district health boards. |
| 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. | FA | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Greendale Residential Care work to minimise the use of restraint. There were no residents on restraint nor using enablers on the day of the audit. All staff receive education regarding restraint minimisation. Staff interviewed were aware of the difference between a restraint and an enabler. |

# 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 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA High | Complaints forms are available at the entrance, with information given on the complaints process as part of the admission procedure and advocacy session with residents and families. Although this information is provided and staff education conducted, residents reported that they felt that the complaints system is not responsive and felt that some staff (refer to 1.1.3) would make their ‘lives more difficult’ if they made a complaint. These residents were not confident that verbal complaints are responded to adequately (refer to 1.1.13.3). | Residents reported that verbal complaints were not always responded to and felt there would be retribution if they made a complaint. | Provide evidence that there is a fair and responsive complaints process.  7 days |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Moderate | The complaints register contains the dates of the complaint being received, acknowledged and when resolved, a summary of the complaint and the actions taken. There were three recorded complaints for 2016. In one of these complaints, the complaints record that they had made a complaint ‘a couple of weeks’ prior and this had not been actioned. The assistant manager/house manager (who was at the service at the time of the complaint) has no record of this complaint being received. | At least one verbal complaint that had been made was not recorded on the complaints register. | Provide evidence that all complaints are included in the complaints register.  30 days |
| Criterion 1.1.3.6  Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer. | PA Moderate | Two of the five residents interviewed provided feedback that their independence and wishes are not respected at all times. These residents felt that they needed to comply with what the staff members requested and that their own individual choices were not always respected (these were requests for pain medication, personal hygiene times, bed times). The other residents and families did not express these concerns. | Residents reported that their independence and wishes are not always respected. | Provide evidence that residents rights are respected at all times.  30 days |
| Criterion 1.1.3.7  Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect. | PA High | Two of the five residents interviewed reported they felt intimidated by staff at times. They referred to staff members (particularly on afternoon shift) where if they did not comply with what the staff member wanted them to do at the time, there was ‘retribution’. These residents reported that their medication had been withheld when requested or given ‘really late”, the staff members talked ‘harshly’ to them and ‘intimidated’ them to comply with the staff members wishes. | Two residents reported that their rights are not always respected. | Ensure residents rights are upheld at all times.  7 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.