# Discover Oasis Limited - Concord House Rest Home

## Introduction

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

The audit has been conducted by 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:** Discover Oasis Limited

**Premises audited:** Concord House Rest Home

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

**Dates of audit:** Start date: 31 January 2017 End date: 31 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:** 8

# 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

Concord House provides rest home level care for up to 15 residents. On the day of the audit there were eight residents living at the facility.

This certification audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The facility manager is supported by a registered nurse. Residents and family interviewed were complimentary of the service they receive.

This certification audit identified that improvements are required in relation to signed admission agreements, essential notification, human resources, timeframes, care interventions, self-medication documentation, material safety datasheets, and environmental restraint.

## 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 low risk. |

Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with their community. The process around managing complaints meets HDC requirements.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established and implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements. Registered nursing cover is available on site or on call twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## Continuum of service delivery

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

Resident’s needs are assessed prior to entry. An information pack is available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed by the registered nurse using InterRAI. Short-term care plans are in use for health changes.

There is an individual and group activities programme running. The group activities programme is overseen by a diversional therapist and implemented by caregivers.

There is an established system of medicines management in place. The caregivers and the registered nurse have completed medication competencies.

Food services policies and procedures are appropriate to the service setting. Resident's individual dietary needs are identified, documented and reviewed on a regular basis.

Residents and family members interviewed were complimentary about service delivery.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The building is two stories. Residents use the ground floor (upper) area. The basement, which is not used for residents, contains the laundry, storage and the facility manager’s office. Access to the basement is locked. The building has a current warrant of fitness.

Systems and supplies are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid/CPR certificate.

Resident’s rooms were individualised. All rooms are single occupancy except for one room, which is a double room that was not occupied on the day of audit. External areas on the grounds were safe. The facility has a van available for transportation of residents. There is a main lounge and separate dining room. There are adequate communal toilets and showers. Fixtures, fittings and flooring are appropriate for rest home level care. Residents were satisfied with the cleaning and laundry services. Chemicals were stored securely. The temperature of the facility was comfortable and constant.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

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. Staff receive regular education and training on restraint minimisation.

## 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 prevention and control programme is suitable for the facility. The programme is led by the registered nurse with support from the facility manager, staff and external agencies. The programme is based upon defined policies and procedures. General practitioners are actively involved in the management of residents with suspected infections. Three staff have attended education on infection prevention and control within the last year. Infections are monitored and practice is reviewed every month. Trends are able to be identified. There have been no outbreaks of infection in the rest home in the period since the previous audit.

## 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 | 37 | 0 | 8 | 0 | 0 | 0 |
| **Criteria** | 0 | 84 | 0 | 9 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policy relating to the Code is implemented. The facility manager and three care staff interviewed (two caregivers, one registered nurse) 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, which continues through the staff education and training programme. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | The service has policies and procedures relating to informed consent, resuscitation and advanced directives. Residents are required to sign an admission agreement on entry to the service. The service uses an industry template which includes the requirements of the aged residential care agreement. Three of five files reviewed included signed agreements. Each file included signed consents and resuscitation instructions. Staff were aware of advanced directives. Discussions with residents and families identified that the service actively involves them in decision making. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Health and Disability Commissioner (HDC) advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed understood their right to advocacy services. The complaints process is linked to advocacy services. Staff have received recent education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, which was evidenced through interviews and observations. Community links are established with community organisations (eg, Alzheimer’s Association, local churches). Some of the residents regularly visit nearby cafes and shops. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and families during the resident’s entry to the service. Access to complaints forms are available. No complaints have been received since the new owners purchased the facility in March 2016. Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers 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 facility manager discusses aspects of the Code with residents and their family on admission. All three residents and two family interviewed reported that the residents’ rights were being upheld by the service.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. Privacy signage is on communal toilet and shower doors. Residents’ rooms are single use with one double room available but not in use. Privacy curtains are installed in the double room.The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that 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 and are covered in the staff education and training programme. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | A Māori health plan is documented for 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. There were no residents living at the facility who identified as Māori.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents’ care plans, evidenced in all five care plans 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: DiscriminationConsumers 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, confirmed during interviews with the facility manager and staff. Professional boundaries are described in job descriptions which were sighted for each position but were not individually signed by staff (link 1.2.7.4). Interviews with the staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | A registered nurse is contracted to work on site 10 – 20 hours per week and on call 24 hours a day, seven days a week. All resident rooms are of a good standard. Resident meetings are held monthly. Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed high levels of satisfaction with the services received.The service receives support from the district health board (DHB). The facility manager attends regular aged care related cluster meetings which assists her with the management of the facility. The homely environment allows for close relationships between the staff and residents.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The staff interviewed understood about open disclosure and providing appropriate information when required. Evidence of communication with family is documented in the residents’ electronic files.Family interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Eight accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event, evidenced on the electronic communication sheet. Plans are in place to add this level of detail into the accident/incident form.Of the eight residents living at the facility, three are Chinese speaking. Interpreter services are available if required through the district health board. Families and staff are utilised in the first instance. Signage is posted in visible locations in English and Chinese. One Chinese resident was interviewed with the assistance of an interpreter. She reported that communication is adequate to meet her needs.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Concord House provides rest home level of care for up to 15 residents. On the day of audit there were eight residents including one younger person under 65 years and one resident under ACC funding. The business was purchased by the new owners in March 2016. A 2016 – 2018 business plan includes the service’s mission, philosophy of care, values and vision. Goals are documented around occupancy, staff turnover and the facility’s reputation with the community. Goals are regularly reviewed with the owners and facility manager.The facility manager is the daughter of the owners. She holds a degree in architecture. This is her first role in aged care. She was orientated to the business by the previous owners and with the assistance of an external consultant. She attends DHB aged-related cluster meetings every two months and has completed over eight hours of education relating to managing a rest home since March 2016. She is assisted by an RN who is employed to work 10 – 20 hours per week and is on call when not available on site. |
| 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 | Caregivers are delegated responsibility in the absence of the facility manager with oversight provided by the RN. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management system has been established. Policies and procedures align with current good practice and meet legislative requirements. Policies have been updated to reflect processes around InterRAI and pressure injuries. They are regularly reviewed as per the document review schedule and are becoming embedded into practice. A system for document control is in place. New policies and updates to existing policies are discussed in staff meetings. The quality improvement programme includes the collection of data and the completion of internal audits. An internal audit programme is established. Adverse event data (eg, falls, infections, skin tears, bruising) is collated and compared month by month (sighted for 2016). Quality data and results, including any resident feedback, is reported in the monthly staff meetings, evidenced in the meeting minutes and in interviews with five staff (three care staff, one cook, one cleaner/laundry). Where improvements are identified, corrective actions are documented, implemented and signed off by the facility manager. A risk management plan is in place. Health and safety policies have been reviewed since the new legislation has come into effect. Interviews were conducted with the health and safety officer who is the facility manager. Staff receive health and safety training, which begins during their induction to the service and was documented in all five staff files reviewed. Health and safety is a regular topic covered in the monthly staff meetings. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. Contractors are inducted into the health and safety programme.Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. Residents at risk of falling are discussed in the monthly staff meetings. |
| 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.  | PA Low | There is an incident/accident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted. Observations are recorded for suspected injuries to the head. Incident/accident data is linked to the quality and risk management programme. Eight accident/incident forms were reviewed. Each event involving a resident reflected follow-up by the registered nurse. Statutory responsibilities are documented in policy but the facility manager was unaware of her responsibilities. A section 31 report was not completed following two separate police investigations. |
| 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 | Human resources policies and procedures are established and are gradually becoming embedded into practice. All five staff files reviewed (one RN, four caregivers) included evidence of signed employment contracts and police vetting. Missing was documented evidence of interviews and reference checking although the facility manager confirmed that both occur. Job descriptions were sighted but there was no evidence to confirm that they had been reviewed and signed by new staff. A general orientation programme that includes health and safety is being implemented that provides new staff with relevant information for safe work practice, evidenced in the five staff files reviewed. Missing was documented evidence that staff have completed their job specific orientation programme.Current practising certificates were sighted for the RN, GP, physiotherapist and pharmacy. There is an annual education schedule that is being implemented. Individual staff attendance records are maintained. Education completed in 2016 included attending external DHB training (wound management, pressure injury prevention management, manual handling, first aid/CPR, code of rights, medication management, controlled drug administration, food safety, fire, confidentiality). Additional topics are scheduled to be covered in the 2017 two-yearly education schedule. The RN has completed her InterRAI training.  |
| 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 staffing policy aligns with contractual requirements. A RN is contracted to work at the facility 10 – 20 hours per week depending on need. She is on site two – three days per week although was unavailable during the audit. When not available on site, she is available on-call and was interviewed during the audit.One caregiver is rostered for each shift. Staffing is flexible to meet the acuity and needs of the residents. Separate staff are responsible for cleaning/laundry (Monday – Friday). Interviews with residents and family confirmed staffing overall was satisfactory. |
| 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. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.Residents’ files demonstrate service integration. Residents’ records are documented using an electronic format with electronic back-up systems implemented. Entries are dated, timed and signed by the relevant caregiver or RN, including designation.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry criteria are documented in the welcome pack. The welcome pack is provided to all prospective residents and their families before admission outlining services available. There are policies, associated procedures and forms used to guide the admission process. The facility manager informs all prospective admissions about the need to be assessed by a needs assessment agency prior to admission. Family members and residents interviewed stated that they had received sufficient information prior to and on entry to the service. The current admission agreement aligns with the ARC requirements and includes exclusions from the service that are listed as additional services for which additional charges may be incurred. Signed admission agreements were missing in two of five residents’ files (link to 1.1.10. 4).  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The service has transfer and discharge policies and procedures in place. The procedures include the use of the DHB developed (ie, ‘yellow envelope’) system to manage information during transfer and discharges.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | All medicines are prescribed by the residents’ GPs (confirmed in review of all eight residents’ medicine charts). All medication charts are pharmacy-generated, recorded correctly and signed correctly by the resident’s general practitioner. Allergy status is recorded. Medicines are administered as prescribed by caregivers and signed for correctly. A medicine round was not witnessed as no residents required medicine administration at lunchtime. All medicines are stored securely when not in use. The facility uses the blister pack medication management system. Medicines are typically delivered every four weeks usually, unless additional medicines are needed. Medicines are reconciled on delivery by the RN prior to use. All medication charts are legible and reviewed three monthly. There are appropriate medication policies and procedures in place including policy for residents who self-administer their medicines. Two subsidised residents were self-administering medicines. Standing orders were not in use.Competency for caregivers who administer medicines is assessed annually when due by the RN. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a food plan in place. Three cooks are employed to cover seven days. The cooks work from 9 am to 1 pm and 3 pm to 6 pm. The majority of food is prepared and cooked on site. The cooks prepare meals to meet both European and Asian preferences reflecting the resident cultural mix. Daily monitoring records are maintained of refrigeration and freezer temperatures. Food is served directly to residents in the adjourning dining room. Food services policies and procedures are appropriate to the service setting. There are four weekly menus in place that have been approved by a dietitian. A dietitian has conducted a menu audit on 19 April 2016, has reviewed and changed the menu and has made some recommendations which relate to documentation. Residents’ dietary profiles are kept in the kitchen. Resident preferences are accommodated and dislikes accommodated. Special equipment is available as needed. Additional fluids and food are available for residents when the kitchen is closed. There are no residents requiring special diets at present. Residents and family members interviewed were complimentary of the food service provided. Residents and relatives interviewed reported satisfaction with the food service. |
| 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 service has a process for declining entry should this be necessary. The manager has not had to decline admission to anyone who is seeking rest home level care. If a person was declined then the reason for declining entry would be recorded and communicated to the resident/family/whānau and alternative options suggested if appropriate. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An initial nursing assessment and initial care plan is required by policy to be completed within 24 hours of admission by the registered nurse (link 1.3.3.3). Personal needs, outcomes and goals of residents are identified. There are a range of assessment tools completed on admission, which include a general assessment, a pain assessment, a continence assessment, a falls risk assessment and a pressure injury assessment. The assessment tools link to the individual care plans. Cultural needs (including language) are recorded in the InterRAI assessment notes and are reflected in the care plans. Residents and relatives interviewed reported that staff understood residents’ needs. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | The InterRAI assessment, assessment summary (which includes triggered clinical assessment protocols (CAPs), outcome scores and the needs identified by the registered nurse’s clinical judgement) informs the development of the care plan. All five care plans reviewed referenced the identified CAPs. One resident had a high risk CAP referenced in the care plan but did not have any specified interventions recorded to guide staff on how to manage that risk. Long-term care plans are individually developed with the resident and/or family/whānau. All care plans are held electronically in the patient management system. All care staff have computer access and document progress notes in the computerised software. All care plans reviewed recorded sufficient detail to guide care staff. Short-term care plans were evidenced in use for short-term needs such dry skin, mobility issues and weight management.Residents and family members interviewed stated they are involved in the care planning process.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Service delivery is guided by the resident’s plan of care. When a resident’s health status changes the RN or facility manager initiates a GP consultation. Short-term care plans are used for residents with short-term needs. Clinical specialists from the DHB are available to provide clinical advice and support. Other specialist involvement, including the mental health service is availableFamily interviewed stated the services provided met their expectations and the needs of their relatives. Family also confirmed they are notified promptly of any health changes to their relative. Caregivers interviewed stated that they have sufficient equipment to provide care as instructed in the care plans. Clinical supplies are available including adequate wound care and continence products. There were no wounds or pressure injuries on the day of audit. Chair scales are used to weigh residents monthly or more frequently if necessary. Weights are recorded in the electronic patient management system.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A diversional therapist is employed part-time to oversee the group activities programme. The diversional therapist visits monthly to develop the programme, which is provided by caregivers. The registered nurse conducts the social assessment and reviews the resident’s individual activities programme as part of the InterRAI evaluation/reassessment process. All residents have an individual social activities plan developed shortly after admission. They can choose to participate in the group programme or they are encouraged to choose an activity from their individual programme. There is flexibility in the programme for offsite group activities and van rides. The programme includes occasional entertainers. Caregivers supervise and escort residents who wish to go for daily walks or van rides. The business owns a seven seater van, which can accommodate five residents, a driver and a staff member. Group activities are held in the lounge. Residents were observed participating in the programme. Residents and relatives interviewed reported satisfaction with the activities programme.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents are reassessed using the InterRAI process at least six monthly. Two of the five residents had been reassessed within the last six months. The others had yet to require a six monthly evaluation. The RN reassesses residents if there has been a significant change in their health status. The GPs review residents three monthly or when requested. Short-term care plans are in use and evaluated regularly. Care plans are goal orientated and evaluated at six monthly intervals and document progress against the resident goals. The review dates are recorded in the InterRAI documentation.Residents and relatives interviewed reported that they are involved when staff evaluate care. |
| 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 | The service facilitates access to medical and non-medical services. Residents, family and the resident’s GP are informed of any referrals. Referrals to medical specialists are made by the resident’s GP in consultation with the registered nurse. Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable. |
| 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. | PA Low | There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemicals are stored safely. Gloves, aprons and goggles are available for staff. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Material safety datasheets could not be located on the day of the audit. |
| 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 displays a current building warrant of fitness which expires on 22 July 2017. The building is a two-storey building consisting of a ground (ie, upper) floor and a basement area. All resident areas are located on the ground (ie, upper) floor. All resident rooms are single occupancy except for one room, which was not occupied on the day of audit. There are six bedrooms downstairs that are used by five boarders and the facility manager who lives onsite. The basement/downstairs area contains the facility manager’s office, the laundry and storage areas. There is a reactive and a planned maintenance system in place. Hot water temperature checks are monitored in resident bathroom/shower areas monthly. Records of temperatures sighted were below 45 degrees Celsius. Medical equipment including the electronic sitting scales have been calibrated and tested in April 2016. Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access to outdoor areas and decks. The external area provides seating and shade. Two of the current eight residents who have dementia are at risk of wandering off the premises. Two of three external doors/gates have safety locks installed to minimise the risk of these residents’ wandering (link 2.1.1.4).Interviews with staff confirmed there was adequate equipment and supplies to provide safe and timely care.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of communal toilets and there are two communal showers. The toilets and showers are identifiable and include vacant/in-use signs. Shower rooms have acceptable materials to support good hygiene and infection prevention and control practices.  |
| 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 thirteen single bedrooms and one double bedroom available for rest home residents. Bedrooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre safely around the room with the use of mobility aids. The rooms are of sufficient size to permit cares to take place. Residents are encouraged to personalise their bedrooms. The bedroom furnishings were appropriate for the resident group.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There was one main lounge and a dining room located close to the kitchen in the resident areas. All communal areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed report they can move freely around the facility and staff can assist them if required. Indoor group activities take place in the lounge.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Personal clothing and linen are laundered on site by the cleaning staff in the laundry, which is located downstairs. The facility manager monitors the effectiveness of laundry and cleaning processes. Residents and relatives interviewed expressed satisfaction with cleaning and laundry services. There is a dedicated cleaner employed for four hours a day Monday – Friday. Cleaning equipment is stored safely when not in use.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum). The orientation programme includes fire and security training as part of the health and safety training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas barbeque is available. A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked regularly by staff.There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate.  |
| 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 communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated (central and space heating) and ventilated with doors that open out onto the decks and windows. Residents and family interviewed stated the environment is comfortable.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The responsibility for infection prevention and control is held by a registered nurse with a current practising certificate. There are clear lines of accountability for infection prevention and control matters within the facility. There is a documented infection control programme that was reviewed on 5 January 2017.Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious where possible. Visitors who are unwell are asked not to visit.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control (IPC) team consists of the Facility Manager, the RN, and the caregivers. The team have access to GPs and staff from the DHB infection prevention and control team if needed. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are a range of written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. These policies were developed by an external contractor. Policies and procedures are reviewed by the IPC team. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The RN receives education on IPC. The RN completed an e-learning programme on 27 May 2016. There was evidence of two of the other staff (ie, a caregiver and the facility manager) having attended education on infection prevention and control within the last year. The facility manager reported that more staff had attended the same external training as she attended but she was unable to demonstrate evidence of their attendance on the day of audit. Informal education on infection prevention and control is provided to staff and residents by the RN as infections occur. Formal education as specified on the education schedule is on the two yearly schedule for 2017. The number of infections is low. Resident education occurs as applicable. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. Infections are managed in consultation with the resident’s GP. They are recorded on a monthly register. The infection control coordinator and facility manager collate information obtained through surveillance. The infection rate is low with urinary tract infections being the most common type of infection. Short-term care plans are completed for all infections. Infection control data are discussed at both the management and staff meetings. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks of infection since the previous audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | PA Low | There are policies around restraint minimisation and environmental restraint. The facility manager is the designated restraint coordinator. A lock was on the front and one side gate preventing two residents suffering with dementia from freely exiting. A third exit is reported as not known to these two residents and allows for the other residents to freely enter and exit. Environmental restraint procedures had not been implemented for the two identified residents. There were no other restraints or enablers in use.The caregivers interviewed understand the difference between restraints and enablers. |

# 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 1.1.10.4The service is able to demonstrate that written consent is obtained where required. | PA Low | The policy is that each resident (or their legal representative) is required to sign an admission agreement on the day of admission. The admission agreement contains consents. In addition, separate consents are sought to guide staff on the any advanced directives the residents may have directed. All five residents in the sample had signed directives regarding resuscitation in place. Missing was evidence of signed admission agreements in a sample of the residents’ files reviewed. | Two of five residents’ files reviewed did not have signed admission agreements on file for the current admission. One of the two residents had an agreement signed covering a previous respite admission. | Ensure each resident signs an admission agreement on the day the resident receives services or in the case of an emergency admission within 10 working days.90 days |
| Criterion 1.2.4.2The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | Although statutory and regularly obligations are defined in policy, the facility manager was unaware that a section 31 report is required to be completed if police conduct an investigation. | The facility manager was unclear regarding the situations that required the completion of a section 31 report. There were two instances where police were contacted to investigate a situation and a section 31 report had not been completed in either instance. | Ensure that all statutory and/or regulatory obligations in relation to essential notification reporting are adhered to.90 days |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The facility manager reported that the appointment of appropriate staff includes an interview, police vetting, and reference checking but this is not documented. Also missing was evidence that each new staff had signed their job description. | The policy requires staff to undergo a formal interview, police vetting and reference checking. The interview and reference checking are not documented. Also missing was evidence of signed job descriptions. | Ensure each staff file includes evidence of an interview, reference checking and a signed job description. 90 days |
| Criterion 1.2.7.4New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | An orientation programme is in place that includes orientation to health and safety and being buddied with more experienced staff for job specific duties. Health and safety processes are signed off by the new employee but components to indicate that staff have completed their job-specific orientation are not documented. | Staff files were missing evidence to indicate that they had completed a job-specific orientation programme. | Ensure that the content of the job-specific orientation programme is documented and signed by both parties when completed.90 days |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Two residents are self-administering their own medicines. They have been assessed as capable by the RN and their GP. They have both signed an agreement to self-administer their medicines. They both have locked storage areas in their bedrooms.  | There is no formal identification documented by the GP on the medication orders for the two residents who are self-administering medicines, and there is no system in place to show that staff check with each resident that they have taken their medicines on each shift. | Ensure that the GP records on the medicine orders of each resident that the resident is self-administering all or part of their medicines, and ensure that there is a system in place to show that staff check that the residents have taken their medicines on each shift when due. 90 days |
| Criterion 1.3.3.3Each 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 | The policy is that residents are assessed by the registered nurse on admission and an initial plan of care is developed to guide staff. A range of assessments are conducted on admission by the RN and shortly thereafter to inform the InterRAI assessment process. Residents are required be assessed by a medical practitioner within two working days of admission. The RN is required to complete the InterRAI assessment process within 21 days of admission. Resident files reviewed did not reflect that all documentation is completed within required timeframes. | 1. One of three residents admitted since the previous audit did not have an initial assessment completed by the RN within 24 hours of admission. The other two residents were admitted many years ago and archived records were not reviewed.2. The three residents who were admitted since the previous audit did not have an InterRAI completed within 21 days. However all three did have an InterRAI assessment.3. The three residents admitted since the previous audit had not been assessed by a GP within 2 working days of admission. | 1. Ensure all newly admitted residents are assessed on admission by an RN.2. Ensure all newly admitted residents have an InterRAI completed within 21 days of admission.3 Ensure all newly admitted residents are assessed by a GP within 2 working days of admission.90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Each resident has an electronic care plan, which is developed by the RN following the resident’s InterRAI assessment. The electronic plan of care is accessible to caregivers. Caregivers record progress notes electronically at the end of each shift. | One resident had a high risk clinical assessment identified during their InterRAI assessment, which was documented in their plan of care. However there was no corresponding intervention specified in the plan of care against the high risk assessment to guide staff on how to manage the resident’s high risk issue. | Ensure all plans describe the required support and interventions that staff need to follow when providing care.90 days |
| Criterion 1.4.1.1Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | There are policies in place to guide staff on the safe and appropriate management of waste and hazardous substances. Policy requires that staff have access to material safety datasheets for all chemicals used on site. | The manager was unaware of where the material safety datasheets were located for sighting on the day of the audit. The cleaner found them in the sluice room the following day after the audit had finished. | Ensure the location of the material safety datasheets are known to all staff.90 days |
| Criterion 2.1.1.4The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | There were no enablers or restraints in place other than environmental restraint for two residents suffering with dementia. The facility manager reported that the remaining residents can freely exit and enter the facility through a side door unknown to the two residents with cognitive impairments. This was confirmed in an interview with one resident who regularly leaves the facility on outings. | There were two residents who due to their dementia, are unable to open the front and side (locked) gates and therefore cannot freely enter/exit the facility. Environmental restraint is covered in policy but the procedures around environmental restraint had not been implemented for either of these residents. Advised, that since the audit the locks have been removed. | Ensure environmental restraint procedures are implemented for any resident who is unable to freely leave the grounds of the facility.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.