# Otago Care Limited - Woodhaugh Resthome and Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Otago Care Limited

**Premises audited:** Woodhaugh Resthome and Hospital

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

**Dates of audit:** Start date: 31 July 2017 End date: 1 August 2017

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 35

# 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.

## General overview of the audit

Woodhaugh rest home and hospital is privately owned. Woodhaugh provides rest home and hospital level of care for up to 73 residents. The total number of beds has reduced from 80 to 73 as 14 rooms are in the process of being converted to seven larger rooms, reducing the total rooms by seven. On the day of the audit there were 35 residents.

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

The manager is a registered nurse and has previously managed the service on two occasions on a temporary basis. She is supported by the owner, team of registered nurses and care staff. Staff have policies and procedures in place to guide them in the safe delivery of care.

Ongoing environmental improvements have occurred since previous audit.

Areas for improvement identified at this certification audit are related to notifying families of incidents, complaints, training for the manager and provisional owner, training for the health and safety coordinator about essential documents, registered nurse review of residents following incidents, staffing levels, storage of chemicals, one disabled bathroom and laundry processes.

## Consumer rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is available. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, advocacy and informed consent. Residents are encouraged to maintain links with the community. Complaints processes are documented in policy.

## Organisational management

The manager is an experienced registered nurse and is supported by newly appointed business manager, a team of registered nurses and care staff.

The business plan has goals documented. Policies and procedures are appropriate to provide support and care to residents’ rest home and hospital level needs and a documented quality programme that is implemented.

Staff receive ongoing training and there is a training plan developed and commenced for 2017.

## Continuum of service delivery

There is a comprehensive information package for residents/relatives on admission to the service. Assessments, care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans demonstrate service integration. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three monthly.

The diversional therapist covering five days a week provides an activities programme in the rest home and hospital level residents that meets the abilities and recreational needs of the groups of residents. The programme is varied and involved the relatives and community.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three monthly.

The menu is designed and reviewed by a dietitian who is readily available. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to recent improvements around the food that was provided.

## Safe and appropriate environment

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and accessible. There are policies in place for emergency management. Systems and supplies are in place for essential, emergency and security services. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed off-site.

## Restraint minimisation and safe practice

The service actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There were no residents using enablers and no residents using restraint.

## Infection prevention and control

The infection control programme is appropriate for the size and complexity of the service. The infection control nurse is responsible for coordinating and providing education and training for all staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 37 | 0 | 3 | 5 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 3 | 5 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Thirteen residents (five hospital and eight rest home) and three relatives of hospital level of care residents confirmed that information has been provided around the code of rights. Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Staff attend Code of Rights training. Discussion with five healthcare assistants and three registered nurses (RN) and the diversional therapist identified they were aware of the code of rights and could describe the key principles of resident’s rights when delivering care.  Interview with the prospective owner demonstrated knowledge of the Code of Health and Disability Services Consumers’ Rights and the Nationwide Health and Disability Advocacy Service, however is still gathering an understanding (link 1.2.1.3). |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are policies in place for informed consent and the service is committed to meeting the requirements of the Code of Health and Disability Consumers Rights. There were signed general consents on all six files sampled. The three registered nurses interviewed confirmed that family involvement occurs with the consent of the resident. Residents interviewed confirmed good information was provided to them to make informed choices. Written directives were recorded for resuscitation status for six of six files sampled (three hospital residents and three from the rest home including one resident on respite and one resident on a younger persons with disabilities (YPD) contract). |
| 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 are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. An Age Concern advocate is available to residents and families and attends resident meetings. Staff receive training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. Residents interviewed confirmed that family and friends are able to visit at any time. Residents verified that they have been supported and encouraged to remain involved in the community where appropriate. There are regular outings into the community. Community groups visit the home as part of the activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Moderate | Information about complaints is provided on admission. Interview with residents informed an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint register. Complaints for 2017 to date were reviewed.  Not all complaints included investigation, timelines, corrective actions when required and resolutions. Results have been fed back to complainants.  Discussions with residents and family members confirmed that any issues have been addressed and they feel comfortable to bring up any concerns.  One complaint is currently being investigated by the DHB. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service has available information on The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) at the main entrance to the facility. There is a welcome information folder that includes information about the code of rights. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service provides physical and personal privacy for residents. There are five double bedrooms which are only used as shared rooms if it is a husband and wife that wish to share. There were no double rooms currently being shared at time of audit. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Care staff interviewed were able to describe how they maintain resident privacy. Staff attend privacy and dignity and abuse and neglect in-services as part of their education plan. Care staff interviewed stated they promote independence with daily activities where appropriate. Resident’s cultural, social, religious and spiritual beliefs are identified on admission and included in the resident’s care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relatives. |
| 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 is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. Management liaise with a local Iwi representative and the Māori liaison group at the DHB for any support or guidance required. There were no residents who identified as Māori on the day of audit. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to attend church services of their choice and are supported to attend other community groups as desired. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of an employment agreement that covers a code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional when carrying out their duties. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with care staff described how they build a supportive relationship with each resident. Residents and the relatives interviewed stated they are treated fairly and with respect by staff |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The staff are committed to providing a service based on the mission statement and philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. The service has implemented policies and procedures that meet relevant standards. Registered nurses and healthcare assistants have access to internal and external education opportunities. Facility meetings and shift handovers enhance communication between the teams and provide consistency of care. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Moderate | Residents interviewed stated they can talk to healthcare assistants or registered nurses if they have any concerns. Residents have the opportunity to feedback on service delivery through resident meetings held with an age concern advocate. Accident/incident forms reviewed evidenced that relatives are not always informed of any incidents/accidents.  Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate | Woodhaugh rest home provides residential services for up to 73 residents requiring rest home or hospital (geriatric or medical) level care. There are 31 dual-purpose rooms and 42 rest home. On the day of the audit, two wings (including the upstairs wing) were closed for renovation and there were 35 residents – 22 at rest home level care including one on a younger person with disability contract and two on respite care and 13 at hospital level of care.  The manager (a registered nurse) provides clinical and organisational oversight has been at the service since 9 May 2017. The manager’s signed job description documents clinical leadership and facility management responsibilities. She is supported by a clinical lead (senior registered nurse). The manager reports weekly by email to the owner and the owner visits the facility at least monthly (as reported by the owner). A new business manager was employed six days prior to the audit.  The goals and direction of the service are well documented in the business plan.  The provisional owner is the son of the existing owners and has lived and worked in the police force in Australia. He intends shifting to Dunedin to provide hands on support to the management. The provisional owner stated that he intends to move the business manager role to manage the operational requirements so that the current manager can focus on a clinical leadership role. The provisional owner has no experience in the aged care industry and legislative requirements and guidelines such as the Code of Rights.  The provisional owner has developed a business plan that includes focus areas on service performance improvement around clinical management, hospitality services, human resources, catering and finance. The business plan includes a transition plan. The current owners will continue to provide support to the provisional owner.  The current manager had an orientation for one week with the previous manager but has not completed eight hours of training relating to the management of a hospital and the business manager and prospective owner are new to the industry. The provisional owner has had training around de escalation and manual handling in the police force. The business manager is currently undergoing orientation provided by the manager. |
| 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 manager reported that in the event of her temporary absence the clinical lead fills her role with support other staff. The prospective owner reports that this will continue. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The manager facilitates the quality programme and ensures the internal audit schedules are implemented. Corrective action plans have been developed, implemented and signed off when service shortfalls have been identified.  Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. All quality improvement data is discussed at monthly safety/quality/risk/staff meetings.  There are relevant policies and procedures that are reviewed regularly. There is a current risk management plan.  The prospective owner intends to initially continue the current quality and risk programme including policies and procedures and once established in the role will review these with support from an external consultant.  The health and safety officer has been in the role for five months and has completed external training. However, the health and safety officer was not aware that the service had a complete hazard register. Health and safety policies have been updated to reflect health and safety legislative changes.  There are resident and relative surveys conducted and analysed with corrective action plans developed when required. The August 2016 resident survey demonstrated a high level of satisfaction with the service and improvements identified as needed in the building have or are being addressed and the service had worked to improve the food service following the surveys.  Falls prevention strategies are in place for individual residents. |
| 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 Moderate | The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents on an electronic database. Thirteen incidents sampled for July 2017 did not demonstrate appropriate documentation and clinical follow-up including sufficient neurological observations. Accidents and incidents are analysed monthly with results discussed at safety/quality/risk/staff meetings.  The facility manager is aware of situations that require statutory reporting. The facility is currently being reviewed by the labour inspectorate following a complaint. An outbreak in June 2017 was appropriately notified to Public Health. |
| 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 | Six staff files sampled (the facility manager, one registered nurse, the life enhancing team manager (diversional therapist), a cleaner/cook and two healthcare assistants) showed appropriate employment practices and documentation. Current annual practicing certificates are kept on file.  The orientation package provides information and skills around working with residents with aged care needs and was completed in all staff files sampled.  There is an annual training plan in place and implemented that has included, but not limited to, infection control, manual handling, prevention and management of abuse and neglect, residents’ rights, cultural sensitivity, falls prevention and pressure injury prevention and management. All six staff files sampled contained a current annual performance appraisal.  The service has had a moderate staff turnover and at the time of the audit there was no plan in place to manage this. Advised that much of that has been to do with immigration and RNs moving on. Residents, relatives and staff interviewed reported on the difficulties presented by the staff turnover |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | There is a documented rationale for staffing the service. Staffing rosters are completed by the owner who is not based on site. Rosters sighted and staff, resident and family feedback demonstrated there are insufficient staff rostered to complete all required tasks and not all staff on duty had sufficient experience (link 1.2.7.3). There is a registered nurse on duty at all times. This was confirmed by rosters, registered nurse interview and caregiver interview. Registered nurses work either eight or twelve hour shifts. In addition to the registered nurse on the floor, the two clinical leads (senior registered nurses) have five hours each of non-resident contact time per week and the facility manager (a registered nurse is on duty 24 hours per week).  There are dedicated housekeeping staff who undertake some of the cleaning duties. Laundry is completed off site. Caregiver task lists include a number of non-care related tasks.  The provisional owner reported an intention to move responsibility for rosters to the facility manager and review staffing levels and task lists. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are electronic. All staff have individual log-in details and only specified computers (those on site and the owner) have access to the database. An external provider manages the database, back up and security.  Individual resident files sampled demonstrated service integration. Medication charts are in a separate folder with medication and this is appropriate to the service.  Electronic progress notes and care plans are in the electronic database and are legible, dated and identified to the relevant staff member 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 | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.  Information gathered on admission is retained in residents’ records. Relatives interviewed stated they were well informed upon admission. The service has an information pack available for residents/families/whānau at entry.  The admission agreement reviewed aligns with the service’s contracts. Five of five long term care admission agreements viewed were signed (the sixth resident was on short term respite care). |
| 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 a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A yellow transfer envelope and the DHB transfer/discharge form is used. A copy of the resuscitation status of the resident and medication is also sent. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication guidelines. Medication reconciliation is completed by two RNs on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior healthcare assistants who administer medications have been assessed for competency on an annual basis. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided and audits undertaken including by pharmacy.  Standing orders are not used. Two self-medicating residents (one for topical ointment application only) had been assessed by the GP and RN as competent to self-administer and these had been reviewed three monthly. The medication was securely stored.  Twelve medication charts over the two levels of care were reviewed. An electronic medication charting system is used along with the robotic system of packaging and prn medications are in blister packs. The electronic system is used for monitoring of effectiveness of medication and also the recording of GP notes. The medication profiles reviewed were up to date and reviewed at least three monthly by the GP. Medication charts have as needed medications prescribed with an individualised indication for use.  The introduction of medimap has meant a seamless communication system between the service, pharmacy and GP around medication changes. |
| 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 | The service has recently employed a qualified chef/baker Monday to Friday and employs two assistants to cover the weekends. Staff have been trained in food safety and chemical safety. There is a four weekly, summer and winter season menu that had been designed by the contracted dietitian. The menu had undergone changes following the appointment of the current chef and received a positive review from the dietitian in July 2017. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. There was evidence two residents had recently been seen by the dietitian. Resident likes, dislikes and dietary preferences were known by the chef. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as vegetarian and pureed/soft and gluten free meals are provided. Food is taken from the kitchen in bain marie containers and served in the dining room by care staff. Fridge and freezer temperatures are checked daily. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits. The chef maintains regular contact with residents as confirmed by the chef and residents. There was an adequate store of food in the kitchen with an additional large supply of dry and tinned goods in store on site that the chef has access to (sighted).  Residents interviewed reported they now enjoyed the food and RNs when interviewed stated the new chef had improved the meals. |
| 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 records the reason/s for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry was referred back to the needs assessment service or referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility has embedded the interRAI assessments within its clinical practice. InterRAI initial assessments and assessment summaries were evident in the files reviewed. Risk assessments have been completed on admission and reviewed six monthly as part of the evaluation process. Additional assessments and monitoring charts such as behaviour monitoring, food and fluid intake and pain monitoring (now on Medimap) were completed according to need. In the resident files reviewed the outcomes of all assessments, needs and supports required were reflected in the care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed were comprehensive and demonstrated service integration and input from allied health.  All resident care plans sampled were resident centred and support needs and interventions were documented in detail.  Care plans were amended to reflect changes in health status and were evaluated and reviewed on a regular basis. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required a GP visit.  Wound assessments, treatment and evaluations were in place for all current wounds. In hospital care, there was one resident with three ulcerated areas in flesh folds. In rest home care, there were two residents with a skin tear each. Adequate dressing supplies were sighted in the treatment room. There was one resident with a pressure injury in rest home care. Pressure injury prevention strategies were included in the long-term care plan of the residents at risk of pressure injuries. Staff receive regular education on wound management.  Continence products are available and resident files include urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.  There is appropriate assessment, monitoring and management of pain.  Monitoring forms are in place to continually assess a resident’s progress where there is a change in health status. |
| 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 | A diversional therapist runs an activity programme Monday to Friday that has set activities with the flexibility to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group and are gender appropriate. A monthly programme of activities is developed and each week the weeks programme is displayed throughout the facility and residents are each delivered a copy of the weeks activity programme.  Assisting with the programme is a volunteer, an occupational therapy student and high school students.  Activities were observed to be delivered in alternative lounge areas including an area where a new pool table had been installed. Contact is made and one on one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There are fortnightly outings/drives (using contracted vans) for all residents (as appropriate) to a range of events eg lunch at the casino, a visit to McDonalds or sightseeing. There is a monthly outing to share a cuppa and a concert with residents from other facilities. The programme includes visits by school children, exercise sessions and a range of intellectual, craft and fun activities.  Attendance logs and a record of individual resident’s activities are kept. A recreational assessment is initially undertaken with an activity plan formulated. This is evaluated 3 monthly and monthly progress notes are recorded in the residents' files.  Resident/relative meetings were held bi-monthly. The meetings are run by a representative from the Aged Concern organisation. A survey of satisfaction with the programme is undertaken three monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by registered nurses’ six monthly or when changes to care occurred. Written evaluations described the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an on-going problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. There is at least a three-monthly review by the GP. Family are notified when this is to occur and are welcome to attend (if resident agrees) and the GP will discuss any issues with them. The GP confirmed this occurs. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. Referral documentation is maintained on resident files. There was evidence in the files sampled of referrals to the DHB and input from Mental Health of Older Persons unit, physiotherapist, wound care nurse specialist, diabetes nurse specialist and district nurse input. The service facilitates access to other medical and non-medical services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low | There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly however not consistently stored safely throughout the facility. Safety data sheets were available. |
| 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 building has a current building warrant of fitness that expires18 February 2018.  The facility employs a maintenance person to undertake maintenance and a gardener/cleaner who maintains the grounds. Daily maintenance requests are addressed and a 12 monthly planned maintenance schedule is in place. Electrical testing has been completed within the last year. Annual calibration and functional checks of medical equipment is completed by an external contractor.  Hot water temperatures in resident areas are monitored monthly. Temperature recordings reviewed were between 43-45 degrees Celsius. Contractors are available 24 hours for essential services.  The facility has a number of lounges and areas with sufficient space for residents to safely mobilise using mobility aids.  Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.  The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| 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 | Some resident rooms have ensuites and for other residents there are communal toilets located close to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff are undertaking personal cares. |
| 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 resident’s rooms are of an appropriate size to allow care to be provided for the resident occupying the room and for the safe use and manoeuvring of mobility aids for that resident. Residents are encouraged to personalise their bedrooms. |
| 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 | The facility has a large lounge dining area for the rest home and hospital residents which is divided into a number of areas for dining and seating placed to allow for individual or group activities. There are also two other large lounge areas and a number of smaller lounges throughout the facility. A pool table has recently been purchased and is in an area often used for activities. The communal areas are easily accessible. |
| 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. | PA Low | There are policies /procedures and audits of the cleaning and laundry service. There are dedicated cleaning staff on duty each weekday and HCA’s also complete cleaning tasks. All linen and personal clothing is laundered off-site but is only collected twice per week for linen and five days per week for personal clothing. There is a locked disused laundry which is used to store chemicals along with clothing and linen awaiting pickup for laundering. Laundry (linen, towels etc) is only collected twice per week meaning there is soiled linen kept on site (in an external laundry room) for up to three days at a time.  Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. There are adequate civil defence supplies including water (stored and changed) and food. There is a gas barbeque available for cooking should there be a power failure along with backup emergency lighting for 2 hours (checked July 2017).  The fire evacuation scheme was approved by the fire service 6 January 2017. There are six monthly fire drills with the last drill being undertaken 7 July 2017. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.  Resident’s rooms, communal bathrooms and living areas all have call bells. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. |
| 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 | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | A registered nurse is the infection control coordinator. She has a job description that outlines the responsibility of the role. The infection control coordinator is responsible for the collation of infection events and reporting to the combined infection control team/staff meeting monthly. The infection control programme has been reviewed annually.  The service had a norovirus outbreak in June 2017. Relevant authorities were notified. Sufficient supplies of provisions to manage infection control including liquid soap in all rooms and plentiful supplies of hand gel were sighted. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has completed external training. The infection control team are supported by the manager (registered nurse).  The infection control coordinator has access to GPs, laboratory service, the infection control nurse specialist and public health departments at the local DHB for advice and the NZ nurses organisation. |
| 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 | The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed and reviewed in consultation with an external infection control consultant. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and annually. Infection control is discussed at handovers with care staff. Healthcare assistants interviewed could describe standard precautions for the prevention of infection.  Resident education is expected to occur as part of providing daily cares as appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Systems in place are appropriate to the size and complexity of the facility. There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is logged onto the electronic system and a monthly report is generated and relevant information is given to staff. Definitions of infections are in place appropriate to the complexity of service provided.  Infection control data is discussed at monthly staff meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule.  There was a vomiting and diarrhoea outbreak in June 2017 which was isolated to 8 residents within two days. It was reported to the DHB and Public Health South who gave advice. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. Staff have received training around managing behaviours that challenge. |

# 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 Moderate | There is a complaints register and all complaints in the complaints folder had been included on the complaints register. Not all complaints had responses within required timeframes and documentation was not available to support the investigation and resolution of all complaints. | One of eight complaints (since January 2017) did not have the date of the response documented. One further complaint had the date of the response documented five weeks after the complaint.  A further three of the eight complaints did not have documentation available to support the investigation and communication of the outcome to the complainant. | Ensure that complaint timeframes as set out in the Code are met and that all complaints are investigated, resolved and feedback is provided to the complainant and that this is documented.  90 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Moderate | Incident forms have a section to document if family have been informed and staff interviewed were aware that family should be informed of incidents. However, this had not consistently occurred. | Of the 13 incident forms reviewed for July 2017 five did not have evidence that the family/next of kin had been informed of the incident. One family member interviewed reported they frequently notice bruises on the resident they had not been informed about. | Ensure family are informed of all incidents.  60 days |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Moderate | The manager has experience in the aged care industry and has previously managed the service on a temporary basis. She has not completed eight hours of management related training in the last year. The previous general manager, who is now based in Auckland has agreed to provide some clinical and quality support to the prospective owner and plans to be on site for three days per month and available remotely at other times. The prospective owner and business manager do not have aged care experience. | The manager has not completed eight hours of training relating to the management of a hospital. The provisional owner has not had experience in the aged care or health industry and has had no training around management of a rest home/hospital. This includes a comprehensive understanding of the Health and Disability Code of Rights. The newly appointed business manager does not have aged care experience. | Ensure the management team (business manager, manager and provisional owner) undertake sufficient training to meet contractual requirements and be able to provide a safe and effective service.  30 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | The health and safety officer has been in the role for five months and has completed on line external training. Health and safety is discussed in facility meetings and the health and safety officer has provided training to staff. The health and safety officer was aware of the section in the electronic database where hazards are documented but only four recent hazards were documented in the database. A complete and reviewed paper based health and safety register/plan is available but the health and safety officer was not aware of this.  There is a risk management plan to minimise other identified risks and individual resident risks are managed on a case by case basis. | The health and safety representative did not know where main hazard register was located. | Ensure the health and safety officer is fully orientated to the role including all relevant documentation.  60 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | When an incident occurs, this is documented on an incident form in the electronic database. The database provides fields for registered nurse review and for documentation of investigation and actions to minimise the risk of recurrence. These had not been completed. The electronic database provides space for one set of neurological observations following a potential head injury but no follow up observations and these were not documented elsewhere. | (i)Three of 13 incident forms sampled did not have documented review by a registered nurse.  (ii)The three sets of neuro obs documented when a resident had a potential head knock only had one complete set of observations documented.  (iii) None of the 13 incident forms sampled for July had a documented investigation to lower the risk of recurrence. | (i-iii)Ensure there is appropriate follow up following incidents including clinical follow up and neurological observations where required and investigation of incidents to reduce the likelihood of recurrence.  30 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Rosters are completed off site and do not include sufficient staff to accomplish all required tasks and taking into consideration the layout of the building. | For the current 35 residents, there are two healthcare assistants that work a full shift and two that work from 7.30 am to 1.30 pm. These staff are required to attend to a number of cleaning tasks and to wash resident dishes and the bain marie large serving dishes after meals as confirmed in interviews and on task lists. Staff, residents and families reported that healthcare assistants have insufficient time and the three families interviewed reported that their family member was often not well groomed, had often not been shaved and appeared haphazardly presented.  The layout of the facility means there is a need for two healthcare assistants and a registered nurse on night shift. Rosters reviewed demonstrated that there is only occasionally a second healthcare assistant on duty.  On the day of the audit one wing had an HCA on their first day and another who had been there 1 ½ weeks. Residents from that wing commented that the staff floundered and did not know their routines. | Ensure there are sufficient experienced staff on duty at all times to meet the needs of all residents, taking into account the layout of the building and the non-care related tasks required of healthcare assistants.  30 days |
| Criterion 1.4.1.1  Service 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 | Staff were seen to be using labelled chemicals appropriately and on interview were appreciative of the risks associated with them. Chemicals were not stored securely. | The two sluice rooms (which also have chemicals stored in them) were unlocked all three times they were checked by the auditors. | Ensure all chemicals are stored securely at all times.  60 days |
| Criterion 1.4.6.2  The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness. | PA Low | Clothing is sent daily Monday to Friday to a commercial laundry. Towelling and sheets are collected twice a week to go to another commercial laundry for processing. Laundry (linen, towels etc) is only collected twice per week meaning there is soiled linen kept on site (in an external laundry room) for up to three days at a time. | Laundry (linen, towels etc) is only collected twice per week meaning there is soiled linen kept on site (in an external laundry room) for up to three days at a time. Personal laundry is not collected or delivered on weekends and three residents and two relatives stated residents own clothes are not always available. Two relatives stated the resident was often not in their own clothes. | Ensure that linen is collected regularly and that systems for laundering of personal clothes ensure residents always have sufficient supplies of their own clothes available.  60 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.