

Golden Age Health Care Limited - Abbey Heights Rest Home

Introduction

This report records the results of a Surveillance 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Golden Age Health Care Limited

Premises audited: Abbey Heights Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 3 October 2017 End date: 3 October 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: 19

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Abbey Heights Rest Home provides rest home level care for up to 24 residents. The service is operated privately and is one of three facilities owned and operated by the same provider. The management team consists one owner/director, the manager and the registered nurse. There have been no changes in the management team since the previous audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management and staff. A general practitioner was not available on the day of audit for interview. Interviews were conducted with the assistance of an interpreter.

This audit has identified four areas requiring improvement relating to statutory adverse event reporting, the non-integration of residents' files, inconsistency of evaluation of residents' progress, and documentation of medication management information. There were no improvements requiring follow-up from the previous audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

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.
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Business and quality and risk management plans include the scope, direction, goals, and values of the organisation. Monitoring of the services provided to the owner/directors is undertaken at least quarterly and is effective. The management team are experienced and suitably qualified to manage the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents and contractual requirements.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurse assesses the resident on admission, with re-assessments conducted at least six monthly, or sooner if there is a change in the resident's needs. Care plans are individualised, based on a range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed on a regular and timely basis.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with cultural needs catered for. Residents verified satisfaction with meals.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that supports a restraint free environment for individual residents. No enablers and no individual resident restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process is available to staff in policy should it be required. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Policy identifies that there is a locked gate to the car park which is an environmental restraint.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, and results are reported through all levels of the organisation. Follow-up action is taken as and when required.

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	12	0	4	0	0	0
Criteria	0	35	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are available in both English and Chinese and located in public areas both upstairs and downstairs at the facility. Content was confirmed by the interpreter at the time of audit.</p> <p>The complaints register reviewed showed that one complaint had been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Documentation shows any required follow up and improvements have been made where possible. This related to food services and follow up included staff education with a food service survey of residents being undertaken. The documented results sighted were positive.</p> <p>The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>Residents and a family member stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although staff and management reported this had not been required since the previous audit as staff speak Chinese, both Mandarin and Cantonese, and there is a Pacific Island staff member who can communicate with the one Pacific Island resident as required. The Pacific Island resident speaks English. An interpreter from the District Health Board was used for resident, family and staff member interviews and to interpret documents, such as complaints management and menus during the audit. The majority of residents speak Chinese.</p> <p>Resident meeting minutes sighted identify that information sharing occurs. This was confirmed in staff and resident interviews.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan and quality objectives, which are reviewed annually, outline the purpose, values, scope and goals of the organisation. The documents describe annual objectives and the associated operational plans. A sample of quarterly service reviews, which are attended by one or both owner/directors, showed adequate information to monitor performance is reported including occupancy, health and safety, internal and external audit results, quality data and emerging risks and issues.</p> <p>Abbey Heights Rest Home manager has been in the role for over eight years and is assisted by a registered nurse who has been in the role since October 2014. One owner/director actively works in the facility at least one day per week. The facility has been owned and operated by the same directors since 2007.</p> <p>The members of the management team hold relevant qualifications. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager confirmed their knowledge of the sector, however they had limited knowledge regarding the regulatory and reporting requirements. (Refer comments in criterion 1.2.4.2). Evidence was sighted of the manager and registered nurse attendance of education related to the roles they undertake. For example, the registered nurse is undertaking post graduate studies in advanced nursing practice at Auckland University of Technology. The manager attends educational sessions for management related to aged care and they both attend in-service education.</p> <p>The service holds an Age Related Residential Care (ARRC) contract with Waitemata District Health Board which includes respite care. Seventeen residents were receiving services under the ARRC contract at the time of audit. Two boarders at the facility receive full services and are private paying. The registered nurse reported that one has had a needs assessment review by the gerontology nurse specialist and did not achieve rest home care level status and one is awaiting a needs assessment to determine if they require rest home level care.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and falls. Quality data is benchmarked using average data against other like facilities via an off-site agency and results sighted show that Abbey Heights maintains their statistics for infection control, skin tears, falls and other incident and accident information well below the average shown.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and corrective action follow up. Relevant corrective actions are developed and implemented to address any shortfalls. One example related to a resident who had a fall. Follow up included obtaining a correct mobility aid, resident education on the correct use of the equipment and staff education related to close observation and encouragement to ensure the resident was confident in use of the equipment. No further falls have been recorded since the corrective action was put in place. Quality improvements and corrective actions are documented on the quarterly service review. The internal audit process had clearly documented corrective actions with re-audits being undertaken if any shortfalls are identified. Resident and family satisfaction surveys are completed annually. The most recent survey (April 2017) showed residents are happy with the services received as no negative comments were sighted. (10 responses were received out of a possible 17 residents).</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed by an off-site provider and are personalised to Abbey Heights Rest Home. They are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager and owner/director described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There is an up to date risk register which is a living document and updated to reflect any new risks that are identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>PA Low</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, corrective actions developed, and actions followed-up in a timely manner. Information is used to improve services as required. The actions taken and outcomes achieved are clearly shown on the quarterly service review meeting minutes and on the incident form. For example, one incident related to medication management (a resident refusing medications) showed the corrective actions involved the GP, family and the resident. It resulted in full review of the resident's medication and acknowledged the resident's right to refuse medication ensuring they were fully informed and understood possible effects of not taking</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>prescribed medications.</p> <p>Adverse event data is collated, analysed and reported to staff at monthly meetings and to the owner/director at the quarterly service review meetings or immediately if it is an area of concern. This was confirmed during staff and management interviews.</p> <p>The manager was not able to describe all essential notification reporting requirements. One police investigation which occurred in April 2017 was not reported to the Ministry of Health. The registered nurse understood the need to report pressure injuries as required and infectious outbreaks.</p> <p>Management advised there have been no coroner's inquests, issues based audits and any infectious control outbreaks since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>As this facility has all but one resident who is not of Chinese origin, the appointment of staff reflects that of the residents. The cultural mix of staff matches that of the residents.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The gerontology nurse specialist from WDH B regularly provided in-service education. Guest speakers also include the quality and risk advisor who is contracted, a fire consultant and Age Concern. Care staff have either completed or are to commence a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The registered nurse is maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. The registered nurse is on call afterhours. If she is unavailable, then a registered nurse from one of the other two facilities owned by the same provider will do the on call. There is one staff member rostered from 11pm to 7am seven days a week. The manager stated there is also a member of staff who sleeps over each night in case</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>assistance is required. The sleepover is not shown on the roster but staff confirmed that this occurs. Staff report that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four-weeks rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. This facility is rest home level care only and the number of staff shown on the rosters meet the ARRC requirements.</p> <p>The registered nurse is rostered five days a week. There are dedicated kitchen and cleaning staff. The manager is rostered five days a week. The owner/manager is rostered eight hours per week. At least one staff member on duty has a current first aid certificate.</p> <p>Staff and management report that agency staff have not been used to cover shifts. Existing staff cover each other for sick leave and annual leave.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>There are no controlled drugs or standing orders.</p> <p>The records of temperatures for the medicine fridge sampled were within the recommended range. The temperature recording had been taken daily by visually inspecting the dial on the fridge, with the owner providing a thermometer for this at the time of audit. There are no vaccines stored onsite and there were no medicines in the fridge at the time of audit.</p> <p>The level of detail on the medication charts is an area for improvement.</p> <p>There were no residents who self-administer medications at the time of audit. There are appropriate processes in place to ensure self-administration is managed in a safe manner.</p> <p>There is an implemented process for the analysis of any medication errors, with two recorded to date in 2017.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>The food service is provided on site by the kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a dietitian within the last two years. Recommendations made at that time have been implemented. The menu reflects the cultural diversity of the</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>resident mix.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the rest home level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by the RN and care staff. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated by the RN as part of the formal six-monthly care plan review. Two of the residents' files sampled have an additional activities plan that were developed by a diversional therapist (though these are dated January 2016).</p> <p>The activities are culturally appropriate. There is a general activity plan that lists the range of activities available. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and family are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme of interest to them, they report there is sufficient amount of activities to keep them occupied and entertained.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Although the care plan re-assessment has occurred, there was limited detail on how the resident is progressing towards meeting their goals.</p> <p>Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for an infections, wounds and falls. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and family/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 08 November 2017) is publicly displayed. The facility had a lot of 'clutter' when the audit commenced. This was pointed out to management and items were removed to clear the clutter away immediately. The manager stated he had been away the previous week and not all supplies had been put away by the staff.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The RN is the infection control coordinator and reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. The infection data is benchmarked externally with other aged care providers three monthly. Benchmarking results sampled indicated that the infection rates in the facility are below average for the sector.</p> <p>The RN is also working on a quality initiative to reduce antibiotic usage.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Policy identifies that enablers are the least</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>restrictive and used voluntarily at a resident's request. The restraint coordinator would provide support and oversight for enabler and restraint management as required. They demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, the facility had no residents using restraints and no residents using enablers. This was confirmed by meeting minutes and by staff. There is a locked gate into the car park. This is for security reasons as members of the public who were not visiting the facility were using the area to park. The key code is displayed so visitors and residents can enter the car park at all times. Residents were observed going for walks and leaving the grounds throughout the day. This environmental restraint is shown in policy and all residents and family are informed of this practice as confirmed during interviews.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	<p>The registered nurse stated their understanding of the need to report pressure injuries (level 3 and above) to the Ministry of Health using section 31 reporting and infectious outbreaks to the DHB/public health. However, the management team did not fully understand all requirements related to essential notifications. This was fully discussed with the management team, including the owner/director on the day of audit and going forward the team stated they will follow the guidelines and processes as set out on the Ministry of Health website. Section 31 report documents were downloaded on the day of audit.</p>	<p>A police investigation was opened in April 2017 following a burglary of a resident's room. This investigation remains open. No reporting occurred to the Ministry of Health.</p>	<p>Ensure all statutory and/or regulatory obligations in relation to essential notification reporting is made to the correct authority where required.</p>

				30 days
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>The required three-monthly GP review is consistently recorded on the medicine chart. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines. For the pro re nata (PRN) medicines in eight of the 10 medication charts sampled, there were no recorded indications for use. In four of these files there was a separate typed sheet (not prescribed by the GP) that summarises the medications that the resident is on and the indications for use of the resident's PRN medications. The RN and caregiver interviewed demonstrated knowledge of the indications for PRN medications.</p> <p>Photos were not present on three of the medication charts sampled, though it is recorded that these residents have declined to have their photo taken. The staff use other methods to assist in the identification of these residents.</p>	<p>Eight of the ten medication charts sampled did not record indications for use for PRN medications.</p>	<p>Provide evidence that the level of detail of PRN medications complies with best practice guidelines.</p> <p>30 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Low</p>	<p>Although there are some systems in place to promote continuity of care, such as the daily care log and notes that the caregivers write in each shift and a verbal handover at the start of each shift, the caregivers do not have access to all the current resident information. The resident's main file, which the caregivers have access to, describe some of the assessment and care planning information. There is an additional progress note folder that the RN records any incident and events or records a weekly summary of the resident's progress. The printed interRAI assessment information is kept in the RN's office, with the most current version accessible electronically by the RN. The caregivers did not have access to the electronic records.</p>	<p>The five of five residents' records sampled did not contain all the current resident information.</p>	<p>Provide evidence that the residents' files are integrated to promote continuity of care.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or</p>	<p>PA Low</p>	<p>The evaluation of care is recorded on the care plan, along with another form that records the resident's wish list (goals). Two of the five care plan sampled showed the last evaluation was recorded with the date, name and signature of the RN, with no other detail recorded. The wish list does partially record the degree of progress (such as partially met or fully met), though the files sampled showed the progress did not relate to the resident's goals (wish list), such as a resident wishing to not have any falls and the evaluation records a statement related to nutrition.</p>	<p>The evaluations did not consistently indicate the degree of achievement or response to the support and/or intervention, and</p>	<p>Provide evidence that the evaluations are documented in sufficient detail to meet the</p>

intervention, and progress towards meeting the desired outcome.			progress towards meeting the desired outcome.	requirements of the standards. 180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.