# Graceful Home Limited - Rose Lodge 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 HealthShare 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:** Graceful Home Limited

**Premises audited:** Rose Lodge Rest Home

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

**Dates of audit:** Start date: 20 November 2017 End date: 20 November 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:** 10

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

This surveillance audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Rose Lodge Rest Home can provide care for up to fourteen residents requiring rest home level of care.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with the managing director, residents and staff.

The managing director is responsible for the overall management of the facility with a registered nurse providing clinical oversight.

Most requirements identified at the previous audit have been met. These include improvements in relation to the use of volunteers; privately paying residents; food safety training the cooks; maintenance issues including testing and tagging of equipment, calibration of medical equipment and secondary tobacco smoke; emergency training and security; an evacuation plan and to the call bell system.

Requirements are still required to advance directives; completion of interRAI assessments in a timely manner and a review of the menu.

Improvements identified at this audit are required to the following: documentation of the complaints register; human resource processes; analysis of trends and the display of a current Building Warrant of Fitness.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents demonstrates they are provided with adequate information and that communication is open.

Communication records are maintained in each resident record. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints.

## 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 medium or high risk and/or unattained and of low risk. |

The managing director provides operational management with support from a senior health care assistant. A registered nurse is on site at least 20 hours a week.

There is a documented quality and risk management system that supports the provision of clinical care and support. Policies are in place and quality and risk performance is reported through meetings. The quality and risk management programme includes analysis and discussion of incidents with an internal audit schedule implemented. Corrective action plans are documented with evidence of resolution of issues.

There are human resource policies documented around selection of staff, orientation and training. Staff, residents and family confirm that staffing levels are adequate, and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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 medium or high risk and/or unattained and of low risk. |

Service provision is coordinated to promote continuity of service delivery. The residents interviewed confirm that they have input into care planning. Resident care planning is changed according to the needs or when progress is different from expected. The service uses short-term care plans for acute problems.

The residents interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is a secure medication system in place. The registered nurse or health care assistants administer medication, and all have a current medication management competency.

Food, fluid, and nutritional needs of residents are provided by cooks who have completed training in food safety. Additional resident requirements for food services are being met.

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

All building and plant is maintained. Equipment is tested annually, and medical equipment is calibrated. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents have access to outdoor areas that are safe.

## 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. |

The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There are no residents using enablers or requiring restraint on audit day.

## Infection prevention and control

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

The policies and procedures guide staff in areas of infection control practice. The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided with a low rate of infections.

## 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 | 1 | 3 | 4 | 0 | 0 |
| **Criteria** | 0 | 41 | 1 | 5 | 4 | 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 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff use verbal consents as part of daily service delivery. Staff interviewed demonstrate an understanding of informed consent processes. Residents confirm that consent issues are discussed with them on admission and appropriate forms are shown to them at this time and thereafter as relevant. All residents' files reviewed include written consent. All residents have the choice to make an advance directive. The form includes sign off by the registered nurse to state that they have reviewed the advance directive annually and the partial attainment identified at the previous audit remains. Two resident records do not include advance directives and a new improvement is required.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Negligible | The complaints policy and procedure refers to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes timeframes for responding to a complaint. Complaint forms are available in the facility. Residents interviewed know how to make a complaint. There is a complaint’s register in place with a monthly note indicating that there have not been any complaints to December 2016. An improvement is required to updating of the complaints register for 2017. The registered nurse states that there have not been any complaints in 2017. There are no complaints from any external authorities as confirmed by the registered nurse who stated that they would have been informed if there had been any.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy and associated procedure is in place to ensure staff maintain open communication with residents and their families. Communication with family members is being documented in residents' records noting that there is very little contact with family. Six residents have no contact with family and four family members for other residents visit very occasionally. There were no family available to be interviewed on the day of audit. Incident forms record evidence of communication with the family following adverse events. Residents interviewed confirm that staff communicate well with them. Management can access interpreting services if required. There are no residents requiring access to interpreting services currently.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Graceful Home Limited is owned and operated by the managing director who is responsible for the services provided at Rose Lodge Rest Home. The managing director was on leave on the day of audit and the registered nurse was providing clinical on call oversight with a senior health care assistant providing oversight of the service and staffing. Both state that they were able to contact the managing director at any time and said that a call would be responded to in a reasonable timeframe as had occurred in the past. The managing director was able to be contacted by telephone to confirm key information, for example, that there had been no major adverse events and that they were contactable. Two agreements for the provision of publicly funded services are in place with Auckland District Health Board (ADHB), which include the aged related residential care services agreement for rest home level care (being provided for nine residents) and the long-term support-chronic health conditions agreement (LTS-CHC). There were no residents receiving care under the LTS-CHC agreement. There is one boarder currently living on site and they are close in age to the residents identified as requiring rest home level care. There is a capacity for 14 residents. There are no privately paying residents living at the service. There is a documented business risk management plan in place, which includes the direction, vision, mission statement, scope of services, objectives and an action plan. The business risk management plan is developed by the managing director in consultation with external business consultants. This has been reviewed in January 2017. The managing director monitors progress against the business plan and consults with external advisors as necessary. An external accountant has financial oversight of the business.The managing director has been a senior caregiver in a psychogeriatric area for 15 years and owns a home and community support business which is providing care for privately paying consumers in their own home. The managing director has completed eight hours plus of education per annum by attending ADHB run training courses. The registered nurse has responsibility for the oversight of all clinical care provided and reports to the managing director. The registered nurse was appointed to the role in August 2016 to provide 20 hours a week support onsite and has completed over eight hours of professional development in the previous year. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is a documented quality plan within the business plan which is reviewed annually. Risk management is incorporated within the business plan. The business plan is monitored by the managing director with advice from external consultants and business advisors. The service implements organisational policies and procedures to support service delivery. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. New policies and procedures reference interRAI; pressure injuries and the changes in health and safety legislation. Outdated policies are archived on site. There is a formal document control process in place. Documents are reviewed two yearly or earlier when required. All policies are reviewed on an ongoing basis by an external consultant.The quality and risk management systems include quality improvement; risk and hazard management; complaints management; management of incidents and accidents; health and safety management; infection prevention and control and restraint management. Residents and family are offered the opportunity to complete a satisfaction survey with last completed in 2016. Respondents documented a high level of satisfaction with service delivery. The next satisfaction survey is scheduled for 2018. Quality improvement data is collected by the health care assistant/administrator who analyses and is responsible for analysing and graphing the data. The data is tabled and discussed at the six to eight weekly staff meetings. This include graphs of infections; hazards, accidents and hazards. Graphs were produced last in February 2017 and an improvement is required to continue with analysis of trends. An internal audit programme is implemented by the managing director or registered nurse. Corrective action plans are documented and there is evidence of resolution of issues as required. There was in the past, an expectation that there be monthly or bi-monthly resident meetings. Family could attend noting that there is little engagement with family by residents. These have not been held in 2017 and residents interviewed stated that they did not see value in the resident meeting as no one was interested in attending. Residents interviewed state that they can talk with the managing director, registered nurse and staff whenever they wish and that they receive information around any changes. Health and safety policies and procedures are documented along with a hazard management programme. These policies have been revised since the changes in health and safety legislation. There is a hazard register in place. There is evidence of hazard identification forms being completed when a hazard is identified. Hazards are assessed for risk; eliminated; minimised or isolated. Health and safety matters are discussed at the staff meeting.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The managing director and registered nurse are aware of situations where there is a need to notify statutory authorities and where HealthCERT would need to be notified of a Section 31 adverse event. There have been no such events since the previous audit.Staff document adverse, unplanned, or untoward events to identify opportunities to improve service delivery, and to identify and manage risk. A review of incidents and accidents since the previous audit as documented in the staff meeting minutes indicates that there is a low number of adverse events.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Moderate | There are policies and procedures in relation to human resources management. A review of staff records indicates that there is recruitment documentation including reference checks; evidence of criminal vetting; an employment agreement signed in most staff files (noting that an improvement is required); a job description; evidence of qualifications and orientation records. There was no evidence of criminal vetting; reference checking; orientation or health and safety training at the last audit however this has been completed and the improvement required at the previous audit has been met.The service was using a volunteer to provide care to residents. The service has made a decision not to have volunteers on site working and the improvement required at the previous audit has been met. Staff are required to have an annual performance appraisal. Three staff files indicated that there is an annual performance appraisal however an improvement is required.Professional qualifications are kept on file. The registered nurse and doctor have a current annual practicing certificate however some other health professionals who visit the service do not have a current annual practicing certificate on file and an improvement is required. The registered nurse has recently passed the interRAI training and is now able to complete interRAI assessments. There is an annual in-service education programme, which includes mandatory training for all staff attending the staff meeting. Attendance is recorded. Training includes key aspects of service delivery and staff interviewed state that it is relevant to them and meets their needs.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a roster policy that includes a roster template. There is always a health care assistant rostered on duty on each shift. The managing director is onsite or on call during the week. The registered nurse is typically onsite three days a week or is on call noting that the registered nurse is employed for 20 hours a week. The registered nurse is flexible in terms of days on site and can respond to requests from staff if they require a visit. Health care assistants call the team leader/health care assistant; a registered nurse or the managing director based on the circumstances of the assistance required. The registered nurse is responsible for calling the general practitioner. The health care assistants interviewed understand when to call emergency services and when to call on call staff. There are a total of 10 staff employed including the managing director; a registered nurse; a diversional therapist; health care assistant/administrator; two cooks and health care assistants. Residents state that there are sufficient staff to support them. Rosters reviewed for the past three months indicate that staff are replaced if on leave.  |
| 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. | PA Low | Entry and assessment processes are recorded. Information is communicated to residents, family, relevant agencies and staff. The admission agreement defines the scope of the service and includes all contractual requirements. Residents confirm the admission process is completed in timely manner with family engaged in the admission process when at all possible noting that there are few family members engaged with residents in the service. A new resident interviewed states that they are orientated to the site and introduced to other residents and staff on the first day. All residents have a needs assessment completed prior to admission to the facility with this held in the resident file. Admission agreements are expected to be completed on admission. Two resident files reviewed did not include an admission agreement and an improvement is required. There are no privately paying residents and the improvement required at the previous audit is no longer relevant to the service. The registered nurse is aware of the need for any privately paying resident to have a needs assessment prior to entering the service.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | A medication policy documented is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. Health care assistants and the registered nurses who administer medications have completed medication competencies for 2017. The staff member observed administering the lunchtime medication complies with regulation requirements. Medicines are kept in a locked trolley. The medications that require to be stored in the fridge are in the kitchen fridge on a separate shelf in a sealed container. Temperatures are checked weekly with these at an appropriate range. There are no residents requiring the use of controlled drugs. The registered nurse was able to describe a process for management of controlled drugs that included these being checked weekly by two staff, one of whom is a registered nurse should they be used. As required medications are charted with documentation of indications for use and maximum dose within 24 hours. One resident is self-administrating medication with a competency completed by the general practitioner confirming that the resident can self-administer medication as per the prescription. The medication is in the resident’s unit in a locked box in a cabinet. There are daily checks that the resident has taken their medication and the handover of the new medication is documented weekly. Resident records reviewed evidenced photographic identification. The photograph in the resident file includes the date of the photograph being taken and confirmation that it is a true likeness. Any allergies or sensitivities are documented on the medical notes and the resident`s medication record. All medications are prescribed individually and signed and dated by the general practitioner. There is no evidence of any transcribing of instructions. The registered nurse checks the medication packs when received from the pharmacy. All medications are current with expiry dates checked and any expired medication returned to the pharmacy when identified.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Moderate | The rest home uses the summer/winter seasonal menu which has been reviewed by a dietitian in April 2014. An improvement to review of the menu identified at the previous audit continues to be required. An individual dietary assessment (nutritional status) is completed on admission for all residents which identifies individual needs, allergies and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over twenty-four hours. Residents are weighed on admission and monthly and evidence is seen of a process to monitor unexplained weight loss or gain. This includes contacting the resident`s general practitioner and notifying the kitchen of extra dietary requirements. The service is managed by two cooks over seven days with both having documentation that evidences food safety training. The improvement required at the previous audit has been met. Special diets can be arranged, for example puree, fortified fluids, vegetarian diets or gluten free diets. Residents interviewed praised the food service.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The service has processes in place to seek information from a range of sources, for example; family (if engaged in the service); the general practitioner; specialists and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The service has appropriate resources and equipment as confirmed through staff interviews and observation of the environment. Assessments are conducted in a private setting with residents seen in the rooms. Residents confirm their involvement in assessments, care planning, review, treatment and evaluations of care. Staff interviewed can identify needs of residents as per the assessments completed. The registered nurse completes a nursing assessment when the resident enters the service. The service is still using special assessments such as the Coombes assessment, falls, dietary and pressure assessments. Other tools are used when required for example a pain scale is used to assess pain. These are completed on entry and reviewed at least six monthly and as required. The registered nurse is catching up with completion of interRAI assessments. The improvement identified at the previous audit around completion of interRAI assessments remains.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans evidence interventions, desired outcomes or goals of each resident. The general practitioner progress notes include reviews that have occurred three monthly or according to timeframes documented. Residents confirm that resident’s current care and treatment meets their needs. This documents the date, method of communication, details of the communication and any comments or follow up required. The registered nurse documents any review of residents with the staff confirming that they are familiar with the current interventions of the resident. Short term care plans are developed, when required and signed off by the registered nurse. They record the detail of information required. The registered nurse signs these off as completed when the issue is resolved. The registered nurse monitors to ensure all cares have been completed in a timely manner. Vital recordings are taken as per resident need and at least monthly unless the resident refuses to have these taken. A review of the forms with attention to specific needs of the resident as identified through interview and through the care plan indicate that residents are monitored as per their individual requirements.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist has an allocation of 30 hours in the service per week. This is an increase of five hours since the last audit. The programme is planned with the residents having input informally on a one to one basis. The activities programme is displayed on a weekly calendar with individual assessments, plans and review documented by the diversional therapist. The diversional therapist completes a daily attendance sheet for each resident. Assessments and plans with evidence of review were sighted in all resident files reviewed. The diversional therapist has input into the interRAI assessment. The diversional therapist keeps the resident notes around activities in a separate folder so that they can complete documentation in a timely manner. The notes are integrated when a page is completed. Regular exercises are provided, and the programme includes intellectual activities, spiritual activities, input from external agencies and supported ordinary unplanned/spontaneous activities including celebrations. The programme reviewed is implemented ensuring the strengths, skills and interests of residents are maintained. Residents are encouraged to maintain activities in the community. Residents report they are happy with the activities provided.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Periods in relation to care planning evaluations are documented. Residents confirm their participation in care plan evaluations. The residents’ progress records are entered in at each shift and as changes occur. When resident’s progress is different from expected, the registered nurse states that they contact the general practitioner. The registered nurse writes comments in the resident file on the days they are on site. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | Graceful Home Limited - Rose Lodge Rest Home owns the service and leases the premises. It is responsible for all internal fixtures and fittings. The rest home includes two single story buildings. The main rest home can accommodate up to 13 residents. It has 11 bedrooms in the main facility of which two are double rooms. There were curtains rails with curtains separating the spaces in both shared bedrooms. The external building contains one single bedroom with ensuite, the office, and the laundry attached but separate. The bedroom was occupied by a resident.A building warrant of fitness (BWOF) is displayed. This has expired in September 2017. An improvement is required to the Building Warrant of Fitness. There have been no building modifications since the previous audit. Maintenance is either done by staff or external contractors. There is a reactive maintenance system in place, which is managed by the managing director in consultation with the accountant. Documentation of improvements is maintained. Seven issues related to maintenance were identified at the previous audit. This related to cracks in the floor and lining of one shower; a hole in the wall in a bedroom; a toilet cistern not firmly attached to the wall. All maintenance issues identified at the previous audit have been addressed. Medical equipment is available, which includes a thermometer and blood pressure equipment. This equipment has been calibrated since the last audit and the improvement required at the previous audit has been met. There was evidence to confirm that testing of electrical equipment (i.e., testing and tagging) had occurred in the last year. The improvement required to testing and tagging of equipment is met. Staff interviewed confirm they have adequate access to equipment.There is an internal courtyard with shade at the rear of the building. The internal courtyard includes a designated smoking area. The previous audit had identified issues related to secondary tobacco smoke entering the building however there was no evidence of this occurring during this audit. The registered nurse confirmed that they work with residents to become smokefree and as a result, now only have three residents who continue to smoke. There are grassed areas in the front of the building with shade, and seating. Hot water temperatures in resident areas are recorded monthly. Records reviewed indicated that temperature testing is within the accepted temperature ranges for the provision of care to vulnerable residents.The service owns a company car for transporting residents. The car has a current warrant of fitness and registration. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The fire evacuation scheme was sighted on the day of audit and confirms that this was signed by the New Zealand Fire Service on 13 August 2012. The improvement required at the previous audit has been met. Emergency and security education is provided to staff during their orientation phase and during refresher training. Staff interviewed confirm recent education on fire management. Staff records sampled provides evidence of attendance at fire safety training. Processes are in place to meet the requirements for emergency management and there is a policy in place. Fire exits are clearly indicated. Staff and residents have completed six monthly fire evacuation drills, and these are documented. The improvement required at the previous audit has been met. Documented policies are in place for emergency management. All registered nurses and health care assistants are required to complete first aid training. First aid certificates are displayed for all staff and are current.There is emergency equipment available. The service has emergency torches, a telephone connected to a landline, a first aid kit, radio, blankets, and carries extra food supplies. The site has only one source of power, which is electricity. The managing director reported that she has an informal agreement with the neighbouring aged residential care facility for the use of alternative power in an emergency and would seek their assistance in an emergency. The facility carries water for use in an emergency if the water supply was disrupted. The water has been replaced since the last audit and there is sufficient water on site for all residents for three days. The improvement required at the previous audit has been met. The call bell system is electric. The call bell indicator panel is located in the rest home hallway in the main building. Staff use the indicator panel to advise them where a bell is ringing. The resident, who lives in the bedroom with the ensuite that is located outside the main building, now has a call bell. This connects to the main lounge area. Staff at night are based in the lounge area and state that they can hear the bell when it is rung. The bell was tested during the audit. The improvement required at the previous audit has been met. The external bedroom has a fire sprinkler system in place and a smoke detector. Staff lock the external rest home doors in the late evenings however the bell now means that the resident can ring at any time with staff responding in a timely manner as confirmed by the resident. A manual bell has been placed in the lounge/dining area and all residents and staff confirm that they have been informed that the bell is there. It was clearly visible on the day of audit. The improvement required at the previous audit has been met.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator (registered nurse) is responsible for the surveillance programme. Surveillance data relating to number and type of infections is recorded in the staff meeting minutes and there is evidence the data being analysed and discussed (refer 1.2.3).Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events with these retained in individual resident files. Staff report they are made aware of any infections of individual residents by way of feedback from the registered nurse, through verbal and written handovers and through documentation in progress notes.A review of the data over the past year indicates that there have been no infections since February 2017. There is a low rate of infections documented.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policies and procedures on restraint minimisation and use of enablers are documented and there are links with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use. There is no evidence of restraint or enablers being in use at this facility. The service has a commitment to a ‘non-restraint’ policy, philosophy and appropriate use of enablers/restraint. Enablers are only used for safety reasons. Staff interviewed understand that the use of enablers is to be a voluntary and the least restrictive means to meet the needs of residents with the intention and/or maintaining of a resident’s independence. Training records evidence training occurs at orientation and is ongoing. The registered nurse is the restraint co-ordinator and can describe their role.  |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7Advance directives that are made available to service providers are acted on where valid. | PA Low | Resident records include advanced directives with a decision made around competency of the resident by the general practitioner. The registered nurse has looked at documenting an advance care directive however this has not been implemented. The form is signed by the resident deemed competent initially however the registered nurse then reviews the advance directive annually and signs to indicate that the advance directive remains. The improvement required at the previous audit remains.Two of five resident records included an advance directive signed by the resident deemed competent and an interRAI assessment for one resident indicates that the resident did not wish to engage in discussions around an advance directive. The other two files reviewed did not have evidence of discussion around documentation of an advance directive and it is unclear as to whether they are competent to make an advance directive or not.  | The review of the advance directive does not clearly document that the resident has been engaged in the discussion around review of the advance directive. The partial attainment identified at the previous audit remains. Two of the five resident files reviewed do not have a signed advance directive. This is a new partial attainment.  | Review documentation of annual review of advance directives to ensure that only the resident deemed competent signs for an advance directive. The risk rating has been raised to low from negligible at the previous audit.Ensure that each resident can sign an advance directive. 180 days |
| Criterion 1.1.13.3An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Negligible | A complaints register is completed for 2016 detailing any complaints received. This includes a monthly record of any complaints or if nil, then this was documented. The complaints register has not been updated for 2017. The registered nurse was confident that no complaints had been received but stated that the managing director would be better placed to confirm this. The folder with the register included any complaint received and any follow up documentation sent to the complainant with a record of actions taken if any were required. There were low level complaints for 2016 included in the folder and none for 2017. Staff interviewed stated that there had not been any complaints from any residents to their knowledge and there were no complaints documented in the meeting minutes noting that complaints was a regular agenda item with evidence of numbers of complaints (or nil if there were none) documented.  | The complaints register did not document a record of any complaints received in 2017.  | Update the complaints register for 2017. 180 days |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The service tables data at the staff meetings and there is discussion around any issues. Data was graphed to enable a review of trends. This was last completed in February 2017.  | Data has not been graphed or trends reviewed since February 2017. This is a new improvement required. | Reinstate review of trends as planned with evidence of service improvement when necessary. 180 days |
| Criterion 1.2.7.2Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | The registered nurse and doctor have a current annual practicing certificate on file. The annual practicing certificate for other health professionals is not current.  | The annual practicing certificate is not current for the podiatrist and pharmacists. This is a new improvement required. | Ensure that a record of annual practicing certificates is retained by the service for visiting health professionals. 180 days |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | Staff have relevant documentation on their staff file. While five staff files include a contract provided to staff, one was not signed by the health care assistant and one contract was not signed by the health care assistant or the managing director.  | Two of the staff files reviewed do not have a signed contract in place. This is a new improvement required. | Ensure that each staff member has a signed contract on file. 60 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Staff are expected to have an annual performance appraisal. Not all staff have a completed annual appraisal on their file.  | Two staff files do not have a current annual performance appraisal on file. This is a new improvement required. | Ensure that all staff have an annual performance appraisal. 180 days |
| Criterion 1.3.1.4Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Low | Three resident files included a signed admission agreement. Two residents admitted in 2017 did not have a signed agreement in their file.  |  Two resident files reviewed did not include an admission agreement. This is a new improvement required.  | Ensure that each resident sign an admission agreement on entry to the service. 90 days |
| Criterion 1.3.13.1Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Moderate | The last review of the menu was completed in April 2014. There are no residents currently losing weight and the registered nurse is monitoring the menu and food services.  | A review of the menu has not been completed since April 2014. The improvement identified at the previous audit continues to be required.  | Ensure that the menu is reviewed in line with residents’ needs. The risk rating remains as moderate however the time frame for completion of the corrective action has been reduced. 60 days |
| Criterion 1.3.4.2The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | The registered nurse completes a nursing assessment when the resident enters the service. New residents who have entered the service since the last audit do not have an interRAI assessment completed within three weeks of entry to the service. Residents have an interRAI assessment with specialised assessments completed six monthly in line with the review of the care plan. The interRAI assessment is not completed at six monthly intervals and the assessment does not necessarily coincide with the review of the care plan. Needs of the residents are identified using the specialised assessment tools reviewed six monthly if the interRAI is not current.  | New residents who have entered the service since the last audit do not have an initial interRAI assessment completed within three weeks of entry. The interRAI assessment is not completed six monthly in line with the review of the care plan. The improvements required at the previous audit remain.  | Ensure that each new resident has an initial interRAI assessment completed within three weeks of entry to the service. Ensure that an interRAI assessment is completed six monthly in line with the review of the care plan. The risk rating has been raised to moderate. 30 days |
| Criterion 1.4.2.1All buildings, plant, and equipment comply with legislation. | PA Moderate | A BWOF is displayed. This expired in September 2017. The registered nurse and diversional therapist were sure that a new BWOF had been issued however this was not able to be found on the day of audit.  | A current BWOF is not displayed.  | Ensure that there is a current BWOF displayed. 90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| No data to display |

End of the report.