# Eastern Services Limited - Gulf Views Rest Home

## Introduction

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

The audit has been conducted by 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](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:** Eastern Services Limited

**Premises audited:** Gulf Views Rest Home

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

**Dates of audit:** Start date: 22 January 2019 End date: 23 January 2019

**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:** 42

# 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

Gulf Views Rest Home provides residential care for up to 45 residents who require rest home level care. The facility is operated by Eastern Services Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, managers, staff, a quality consultant/nurse practitioner, a wound care nurse specialist and a general practitioner.

A continuous improvement rating has been awarded relating to a reduction in urinary tract infections.

Areas requiring improvement relate to aspects of recruitment and orientation of new staff, the education programme, medication competencies, integration of resident’s information, timeframes around interRAI assessments, long term care plans and entries in progress notes. Resident information gathering tool used as a handover sheet with information not linked into residents’ records and destroyed after approximately three months.

## 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. |

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication was evident between staff, residents and families, is promoted and was confirmed to be effective. The service has access to an interpreter service if required. Staff provide residents and families with appropriate information they need to make informed choices and to give informed consent.

Residents who identify as Maori have their needs met in a manner that respects their individual culture, values and beliefs. Staff were aware of their responsibilities in relation to any evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialists at the district health board to support best practice and to meet the needs of the residents.

The complaints register was up to date. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## 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. |

Eastern Services Limited is the governing body and is responsible for the service provided. A business plan includes a purpose, vision and goals. There is regular reporting by the nurse manager to the owners.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The nurse manager is supported by a quality consultant/nurse practitioner and registered nurses.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Quality meetings include infection control and health and safety. Staff and residents’ meetings are all held on a regular basis.

There are policies and procedures on human resources management. An in-service education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The nurse manager and two senior registered nurses are rostered on call after hours.

Clinical records are legible and stored securely.

## 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. |

Access to the facility is appropriate and manged effectively with relevant information provided to the resident/family on admission.

The registered nurses and a general or nurse practitioner assess residents’ needs on admission in a timely manner. Care plans are individualised based on a range of information and accommodate any new problems that might arise. Records reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health providers/services as required.

The planned activities programme provides the residents with a variety of individual and/or group activities. Interests of the residents are considered. Links with the community are encouraged at every opportunity.

Medicines are safely managed. An electronic medicine management system is in use.

The food service meets the nutritional needs of the individual residents and special needs are catered for. A food safety plan has been registered. Residents and their families 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. |

A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

The facility is built on three levels with a lift between the floors. Residents’ bedrooms provide single accommodation and adequate personal space. Lounges, dining areas and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. Laundry is washed both on site and off site at another facility nearby.

## 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 restraint policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents’ needs. At the time of audit there were no residents using restraints or enablers.

## Infection prevention and control

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

The infection prevention and control programme is led by the nurse manager and aims to prevent and manage infections. The programme was reviewed in December 2018. Specialist advice is accessible when needed. Staff demonstrated a good understanding of the principles and practice around infection prevention and control. Policies and procedures are available to guide staff and the staff are supported by an ongoing infection control education programme.

Aged specific infection surveillance is undertaken which is practicable for the size and nature of this aged care service. The results of the infection surveillance programme are reported to the management team and staff on a regular basis. Follow-up action is taken as and when needed.

## 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 | 42 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 1 | 87 | 0 | 1 | 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 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Gulf Views Rest Home has developed and implemented policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity, respect and privacy. Training on the Code is included as part of the orientation process for all staff employed. Staff advise they have ongoing training on the Code, although records of this were not available for review (refer to criterion 1.2.7.5). |
| 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. | FA | An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.The residents’ records reviewed had the applicable consent forms signed by the resident, and/or family and/or enduring power of attorney (EPOA). Copies of EPOA documents are obtained where present, and individual resident records noted if these had been activated or not. Advance directives are encouraged and discussed at the time of admission and signed by the resident if competent (as documented by their general practitioner). Additional guidance is sought from the resident about the management of episodes of acute illness, and whether the resident wants to be transferred to the DHB hospital if required care was unable to be provided at the time in the rest home. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received, and families/whanau were actively encouraged to be involved in their relative’s care and decision making. This included discussions with staff related to the resident’s annual multi-disciplinary review meeting.Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident’s right to receive, refuse and withdraw consent for care/services. Staff interviewed demonstrated good knowledge of informed consent as evidenced in the residents’ records, care planning and observations at the time of audit. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocates whenever required.Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were encouraged to become actively involved as an advocate for their relative and felt very comfortable speaking with staff. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | There are no set visiting hours and family/whanau are encouraged to visit with the exception where possible of during meal times. Residents are fully supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident’s progress records and care planning, such as visiting the local shopping mall, library, café, movies, dentist, and optician, or community groups visiting the facility. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The concerns and complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility. Interviews with residents and families confirmed this.The complaints register shows the last complaint was received prior to the previous audit. The complaints register meets the requirements of Right 10 of the Code. The nurse manager (NM) is responsible for the management of complaints. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required. The NM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admission agreement. The information packs were reviewed for those enquiring about the service and the pack for residents/whanau when the resident is admitted to the facility. The Code is displayed in all service areas together with information on advocacy services, the activities programme brochures, how to make a complaint and feedback forms.The family/whanau and residents that were interviewed on this topic reported that the Code was explained to them on admission. Family/whanau and residents expressed satisfaction with the care at the facility provided by the staff. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.Staff were observed to maintain privacy throughout the audit. All residents have their own single occupancy room. Residents are encouraged to maintain their independence by participating in community activities and/or the activities programme, however, participation is voluntary. Care plans sighted included documentation related to the resident’s abilities and strategies to maintain independence.Records reviewed confirmed that each resident’s cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their individual care plan.Staff understood the service’s policy on abuse and neglect including what do should there be any signs. Family members advised they visit regularly and their family member is always well presented. Residents and family members advised they always observe the staff treating residents with kindness and respect and speak very highly of staff and the care provided. It was unclear when staff education on abuse and neglect last occurred (refer to criterion 1.2.7.5). A member of parliament visited the rest home in late 2018 and met with residents and discussed the elder abuse response service (EARS) and telephone supports available. Photographs of this event were sighted. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Staff support residents in the service who identify as Maori, or who express an affiliation with the Maori culture to integrate their cultural values and beliefs. There is one resident who identifies as Maori. A resident advised being given a copy of the facility Maori health plan to review at admission and was very satisfied with rest home staff and cultural processes. Two registered nurses and the nurse manager interviewed reported that there are no barriers to Maori accessing the service. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori residents and importance of whanau and their Maori culture. A Maori Health Plan for the organisation was available. The activities programme includes cultural activities. A marae visit occurred in 2018, and photographs of the event were sighted. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The residents’ records reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. Individual resident’s needs are identified during the admission assessments and were reviewed regularly during the care planning and evaluation processes. Residents interviewed were satisfied their individual needs were being met in a timely manner. The family/whanau interviewed reported that the staff are meeting the needs of their relatives and that their relative was treated in a manner that supported their cultural beliefs and values. This was also evidenced at the time of audit with observed interactions. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family/whanau and residents reported that they are very satisfied with the care provided. The families/whanau expressed that staff knew their relatives well, that relationships are built, and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they were aware of the importance of maintaining professional boundaries. Staff responsibilities were outlined in the job descriptions and ‘house rules’ reviewed by the lead auditor. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Evidenced-based practice was observed and evidenced in interviews with the two registered nurses, health care assistants and through care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by the general practitioners, links with other health professionals, including the wound care nurse, mental health services, and DHB nurse specialists and allied health staff. An electronic medicine management system is used. Associated records were legible and are audited on a weekly basis. Annual multi-disciplinary reviews are conducted for residents with input from the pharmacist, general / nurse practitioner, family and rest home staff. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The family/whanau interviewed confirmed that they are kept informed of their relative’s well-being including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of open disclosure was seen in the residents’ progress records, accident/incident forms and discussed at shift handover.The staff communication book was reviewed as a means of communication between staff and a shift handover from the morning to the afternoon shift was observed. Another diary is used for planning the residents and information to be reviewed or followed up during GP visits.All except one resident can effectively communicate in English. Family members of this resident discussed the resident’s needs with staff at admission. Staff were observed to communicate the resident’s needs at handover and identify to the oncoming shift what specific gestures / phrases meant. Staff interviewed identified that their communication was effective. The Counties Manukau District Health Board (CMDHB) provides an interpreter service if required and information is accessible for staff should this be required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Gulf Views Rest Home has been privately owned by the same owners for 26 years. A business plan 2016-2021 includes a purpose, scope and objectives. Management meetings between the nurse manager (NM) and the owners are held on site two monthly. Interview of the NM and review of meeting minutes evidenced review of the objectives and reporting of all matters and activities concerning the service including but not limited to staffing, occupancy, health and safety, in-service education, complaints, audits and maintenance. The service philosophy and mission statement are in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.The nurse manager has extensive experience in the aged care sector, is an RN and was has been in the role for 24 years. The NM is supported by a quality consultant/nurse practitioner and senior RNs. The NM is also supported by the owners and a business manager. The NM is part of a peer review group within the aged care sector and is the chairperson of the NZNO Gerontology Auckland branch. Interview of the NM and review of their personal file evidenced they have undertaken on-going education in relevant areas. Three of the five RNs are interRAI trained and have current competencies.Gulf Views Rest Home is certified to provide rest home level care. On the first day of audit there were 42 residents, including one respite resident and one resident over the age of 65 years under an ACC contract. The service has contracts with the DHB to provide Aged Related Residential Care and Community Residential Respite Services.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the absence of the nurse manager, one of the senior RNs deputises for the facility manager with support from the administrator and the owners.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality plan and risk management plan are used to guide the quality programme. An organisational chart, a mission statement and philosophy are included.Resident and family/visitor satisfaction surveys were completed in 2018 and results indicated that residents and families were very satisfied with the services provided. Completed audits for 2018 and 2019, clinical indicators and quality improvement data was recorded on various registers and forms. Review of the quality improvement data provided evidence the data was being collected, collated, and analysed to identify trends and corrective actions are developed, implemented and evaluated. Quality meetings (including infection control, health and safety) are held two monthly and staff meetings monthly. The NM stated quality data is discussed at the quality and staff meetings. Minutes of meetings evidenced quality data is reported, with analysis and any trends identified. Staff reported they discuss clinical indicators and corrective actions at the staff meetings and that the graphs generated are helpful as it is easy to see that corrective actions have made a difference. Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and reference legislative requirements. Policies / procedures are reviewed two yearly and were current. Staff confirmed they are advised of updated policies and that the policies and procedures provided appropriate guidance for the service delivery. A health and safety policy is available. A new health and safety representative has been appointed and is booked to complete a health and safety course. The NM is managing the role in the interim. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, environmental, legislative compliance, contractual and clinical risk. |
| 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 | An accident and incident policy is in place. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Review of completed forms confirmed this. The NM is responsible for receiving and reviewing the accident/incident forms. The administrator is responsible for inputting the data. Incidents/accidents are investigated and corrective actions put in place. Residents’ files evidenced communication with families following adverse events involving the resident, or any change to the resident’s health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.The NM stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The NM reported there have not been any essential notifications to external agencies since the previous audit. |
| 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 on human resources management. The skills and knowledge required for each position was documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed along with employment agreements, confidentiality statements, house rules and acceptable behaviour in the workforce. Staff files evidenced not all staff have reference checks and none of the files evidenced police vetting has been undertaken prior to employment.An orientation/induction programme is in place and all new staff are required to complete this within two months of employment, however, not all files evidenced an orientation had been completed. Staff performance is reviewed at the end of the orientation and a performance appraisal is completed annually thereafter. Staff files reviewed confirmed this. Orientation for staff covers the essential components of the service provided. Staff confirmed they have completed an orientation and confirmed their attendance at on-going in-service education and that their performance appraisals were current.The NM is responsible for oversight of the in-service education programme. The education programmes for 2018 and 2019 were reviewed and evidenced education is provided on site and externally. It was difficult to ascertain from the programme exactly what subjects had been provided to staff. The individual attendance records did not evidence that all required subjects had been provided within the last two years. There was good evidence of the registered nurses and the enrolled nurse attending sessions externally. Not all registered staff responsible for medication management have current medication competencies.There are care staff who have completed a New Zealand Qualification Authority education programme. The NM advised the programme is to be reintroduced and care staff encouraged to complete the course. Annual practising certificates for all health professionals who require them were current. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The NM works full time and is on call after hours for on-clinical matters. Two senior RNs are rostered on week about for any clinical issues. Five RNs and one EN are employed over 24 hours, seven days a week. There are dedicated cleaning and laundry staff. Two activity staff work Monday to Friday. Care staff interviewed reported there were adequate staff available and that they can complete the work allocated to them. Residents and families interviewed reported there were enough staff on duty that provided them or their relative with a high level of care. Observations during this audit confirmed adequate staff cover was provided. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Moderate | The records were being kept secure in all nurses’ stations and were only accessible to authorised people. On the day of admission, relevant information is entered into the resident’s record by the registered nurse. The initial assessment and medical examination by the general practitioner or nurse practitioner was documented in all sampled files. The date of admission, full and preferred name, date of birth, gender, ethnicity/religion, national health index (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and contact phone numbers were all completed in each resident’s record reviewed. A photograph of the resident is also present. Medicine related records are predominantly electronic. Information related to monthly weights and vital sign monitoring, as well as bowel function for at risk residents is not consistently integrated into individual resident’s records. Full residents’ records remain traceable and information is held within the required time frames which also encompass the requirements of the (Retention of Health Information) Regulations 1996 Act with the exception of the ‘daily report for caregivers’. Progress notes are not always documented at the required frequency by the registered nurses (RN) and / or the enrolled nurse (EN). Refer also to criterion 1.3.3.3.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The organisation has an admission agreement which is based on the Aged Care Association agreement. The residents’ records reviewed have signed admission agreements by the resident/family/representative or enduring power of attorney (EPOA). Information packs for residents and families admitted to this rest home service were available and reviewed. All residents must be assessed prior to entry to the service by the needs assessment service coordinator (NASC) from the district health board (DHB) or gerontology nurse specialists / gerontologist if new short term care is required. Information on prospective residents and their care needs is obtained. The nurse manager is responsible for accepting or declining potential admissions. There is no smoking on site. Residents and family / whanau interviewed confirmed they were provided with suitable, timely information on the rest home prior to the admission.A paper-based register is maintained of all residents, admission and discharge dates, and nights away from the facility for any reason. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner. An escort is provided as appropriate. The service utilises the ’yellow envelope’ system when transferring a resident to the DHB acute care services. There is open communication between all services, the resident and family/whanau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident ensuring continuity of service provision. This includes providing copies of enduring power of attorney documentation where applicable. All referrals were documented in the progress records and a copy of the referral retained in the individual resident’s records sighted. A summary page within each resident’s record is documented at admission and updated over time and includes key information required in the event of each resident’s discharge or transfer. |
| 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 | The medication management policies include all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated sound knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. A medicine competency assessment framework is in place. Some staff are overdue annual competency review. Refer to criterion 1.2.7.5. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request, and as a component of each resident’s annual multi-disciplinary review. A six monthly audit of controlled drugs is completed.The records of temperatures for the medicine fridge were maintained. There is no medication room but a locked trolley and cupboard was sighted. Vaccines are not stored on site. Electronic medicine records were observed that included the GP name and registration number and dates of all reviews undertaken by the GP. On infrequent occasions paper based medicine records are maintained for new residents or new medications and communication processes between staff related to these were observed. All requirements for pro re nata (PRN) medicines are met. The outcomes or effect of medication given is recorded for all pro re nata medicines. Standing orders are not used.There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.Medication errors are required to be reported via the incident management system. Reported events are investigated and responded to in a timely manner. Residents and family/whanau interviewed confirmed they are consulted with and / or advised of any changes to medicines or dosage in a timely manner.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The kitchen manager oversees the food service and is supported by six other staff over the week. The menu plans have been provided to a dietitian for review in late 2018 and emails confirm a menu review is currently in process. Records available identified the menu was previously reviewed in 2014. Recipe cards are present. The main meal is provided in the evening. All baking and meals are cooked on-site in the kitchen. The dining room is in close proximity to the kitchen. The registered nurses complete a dietary profile for each resident when they are admitted to the service and a copy is retained in the kitchen. Any food allergies or preferences are noted, and substitutes offered at meal times where required. Nutrition profiles are reviewed six monthly or sooner where applicable. In between meals and suppertime snacks are available. Nutritional supplements are also available as required.All aspects of food procurement, production, preparation, delivery and storage comply with current legislation. Temperatures are monitored and recorded daily of the freezer and fridges. Dry goods are stored appropriately in the pantry and rotation is noted with goods dated. Chemicals are stored safely. Cleaning schedules are maintained. Applicable staff have completed or are in the process of completing industry approved food safety education. The service is registered for the required food safety plan. Special equipment to meet resident’s nutritional needs is available. The residents interviewed were satisfied with the variety, quantity and appearance of the meals provided.The dietitian is available and is consulted about individual resident’s nutritional needs where this is clinically indicated or requested. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | In an event that the service cannot meet the needs of the resident, the resident, family/whanau and the NASC service will be contacted so that alternative residential care accommodation can be found. An example would be if a resident required hospital level care or secure dementia care. The resident agreement has a clause which states when an agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the individual resident.The nurse manager reported that declining access for residents rarely occurs and full assistance would be provided to the family/whanau and resident during this process.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin assessment and other tools as deemed necessary, to identify any deficits or triggers to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. The interRAI assessments were current as at audit (had been completed in the last six months and reflected the current needs of the residents), but prior to this, some assessments have not consistently occurred within the required timeframes for sampled residents (refer to 1.3.3.3.). Three registered nurses are interRAI trained, including two RNs that completed this training at the end of December 2018. Prior to this only one RN was able to undertake interRAI assessments and noted being unable to keep up with completing these assessments within the required timeframes. Residents and families confirmed their involvement in the assessment process and individualised resident goals have been identified and documented. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. Initial long term care plans are not consistently completed within 21 days of admission (refer to 1.3.3.3). Allergies and sensitivities are recorded on the care plan, the medical records and the medication record. The needs identified by the interRAI assessments (when completed), and resident goals/needs were reflected in care plans reviewed. The long term care plans were sufficiently detailed and provided clear guidance for care staff on individual resident needs. Short term care plans are developed for short term events including wound care requirements and infections. Recently these have been documented on coloured paper to make these more prominent in the resident’s record.The GP’s notations are clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Allied staff documentation includes assessments, treatment provided and the ongoing plan of care where applicable. An annual multi-disciplinary review meeting is conducted with the input of the GP, RNs and pharmacist. Health care assistants and activities staff also contribute to the information discussed. Residents and families reported participation in the development and ongoing evaluation of care plans and the resident’s annual multidisciplinary meeting, and were satisfied their individual needs were being met in a timely manner. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care 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. Progress notes sampled detailed care provided in response to changes in the resident’s condition, including suspected infections, accidents / incidents, changes in medicines and residents or family /whanau requests. A GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. The wound care nurse specialist advised that she is contacted in a timely manner for complex wounds or wounds that have the potential to change. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available appropriate to the level of care provided and in accordance with the residents’ needs. |
| 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 monthly activities programme is provided by two activities staff who normally both work 9 am and 3 pm weekdays, with one staff member working a half day alternate Fridays. The activities programme predominantly covers Monday to Friday, although some weekend activities are scheduled. A social assessment and history is documented for each resident. The long term care plan includes an activities objective/plan for each individual resident and this is reviewed when the care plans are evaluated at least six monthly or earlier when required. The activities staff develop the activity programme based on the monthly theme which changes from month to month to ensure variety. There is a library area on site, a music keyboard, televisions, DVDs/movies and music. The more energetic activities are planned to occur in the mornings. The activities staff advise they are well resourced. Residents’ birthdays are celebrated with the resident’s prior consent.Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events including outings are offered. The activity timetable is displayed on noticeboards throughout the facility, and the days schedule is detailed with timeframes in the dining room / lounge area. Photo boards display photos of special events held. Residents’ interviewed confirmed they find the programme very enjoyable, and participation is voluntary. Activities evaluations are completed at least six monthly, and additional comments also noted in progress notes. Daily attendance records are maintained by the activities staff and these were sighted. A van is available for external outings into the community. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | If any change is noted it is reported by health care assistants to the registered nurse at the time. Timely communication was observed during audit. Evaluations are also noted in progress notes and were well documented where there were concerns about a resident or changes in their condition / needs.Formal evaluations of the care plans occur at least six monthly, and in conjunction with the interRAI re-assessment (refer to criterion 1.3.3.3) or as a resident’s needs change. 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 infections and wound care. Evaluations of treatment provided included (but were not limited to) blood glucose levels, nausea, pain and challenging behaviour as noted in the residents’ progress notes, or specific monitoring records, or in the electronic medicine management records. When necessary for unresolved problems, the long term care plans are updated accordingly. Residents and family/whanau interviewed provided examples of involvement in evaluation of progress and resulting changes. Some records including the results of monthly weights, vital sign monitoring and bowel charts are not consistently integrated into the individual resident’s record. Refer to criterion 1.2.9.10. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Residents are supported to access or seek referral to other health and/or disability service providers. The service has general practitioners or a nurse practitioner from three local general practices. The residents may also choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested the general practitioner or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents’ records. The resident/family/whanau are kept informed of the referral process as verified in the documentation and interviews. Any acute/urgent referral is attended to immediately, such as taking the resident to an after-hours medical service or sending the resident to accident and emergency in an ambulance, if the circumstances dictate. The resident’s right to refuse referral to other health services is also noted. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes are in place for the management of waste and hazardous substances, including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Chemicals are provided within in a closed system. Education on chemical safety has been provided. Staff confirmed this.Observations provided evidence that hazardous substances were correctly labelled, the containers were appropriate for the contents, including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled was provided and being used by staff, including gloves, aprons, masks and full visors. The laundry and cleaners demonstrated sound knowledge of use. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Gulf Views Rest Home is on three levels with a lift between floors. Passageways are wide enough with hand rails to allow residents and staff to pass easily. Bedrooms are large enough to store mobility aids.A current building warrant of fitness is displayed that expires on the 4 March 2019. Review of documentation provided evidence there are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for purpose. A maintenance person ensures a proactive and reactive maintenance programme is in place and buildings, plant and equipment are maintained to a high standard. Documentation reviewed, the NM interviewed, and observation confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.There are external areas available that are maintained, safe and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. The gardens are well maintained by a contractor who works two to three mornings a week. Residents are protected from risks associated with being outside.Care staff confirmed they have access to appropriate equipment, equipment is checked before use and they are competent to use it. Hot water temperatures at resident outlets are within the required range.Staff interviewed confirmed they know the process they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirmed they can move freely around the facility and that the accommodation meets their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There is a mix of bedrooms with their own full ensuites, and ensuites (toilet and wash hand basin) shared between two bedrooms. There are adequate numbers of toilets and bathrooms throughout the facility including toilets for visitors. Residents and families interviewed reported that there were enough toilets and bathrooms that are easy to access.Appropriately secured and approved handrails are provided in the toilet/shower areas with signage and other equipment/accessories available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | Bedrooms are big enough for personal space and allow residents and staff to move around within the bedrooms safely. All bedrooms offer single accommodation. Residents interviewed all spoke positively about their rooms and how easily they could move around in them. Rooms are personalised with furnishings, photos and other personal adornments. Some rooms have sea views with ranch sliders and balconies.There is room to store mobility aids such as walkers. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are numerous areas for residents to frequent for activities, dining and relaxing. Areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents and families confirmed this. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is both washed and dried on site and at another facility nearby. The laundry staff member demonstrated good knowledge of the laundry processes. Residents and families reported the laundry was well managed and their clothes are returned in a timely manner.There are dedicated cleaners on site who have received appropriate training. Interview of a cleaner and training records confirmed this. The cleaners have lockable cupboards to store chemicals. All chemicals were in appropriately labelled containers. Residents and family stated the facility is cleaned to a high standard. Observations during the audit confirmed this. The NM stated they monitor the cleaning and laundry processes. Effectiveness of the cleaning and laundry processes is monitored through the audit programme.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The evacuation plan was approved by the New Zealand Fire Service on the 2 September 1997. Emergency and security documentation is in place. Six monthly fire drills are carried out and a competency questionnaire is completed by staff as part of their annual performance appraisal. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted, and all equipment has been checked within required timeframes. There is always at least one staff member on duty with a current first aid certificate. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQ’s. There are call bells to alert staff. Residents and families reported staff responded promptly to call bells. Testing of the time to respond to a call bell was carried out during the walk through and staff were observed to respond very quickly.The external doors are secured at 5pm. There is a bell at the front door for visitors to ring after hours. A security firm monitors the facility three times during the night. Sensor lights are situated around the exterior of the building. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Heating is provided by central heating ducted in the ceilings. Heat pumps are provided in the dining and lounge areas to cool the air in summer. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. The facility, both internally and externally, including the grounds, are smoke free. All resident areas are provided with natural light.Family and residents interviewed confirmed the facility is maintained at a comfortable temperature. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The service has a documented infection control programme which was reviewed in December 2018. The infection control programme is aimed at minimising the risk of infections to residents, staff and visitors to the facility.The nurse manager (NM) is responsible for facilitating and providing oversight of the infection prevention and control programme, with the support of an external specialist nurse. The roles and responsibilities for the oversight of this programme are documented. The nurse manager interviewed monitors infections with the support of the RN’s and EN, by using standardised definitions to identify infections, and monitors organisms related to antibiotic use. Information is documented on the monthly surveillance record. Infection control is discussed at regular staff and management meetings. If there is an infectious outbreak the NM advises this would be reported immediately to staff, and where required to the DHB and public health services. There have been no outbreaks since the last audit.The two registered nurses interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover, and the GP advised, and short term care plans are implemented. This is documented in the progress records. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one on one communication, at shift handover, in short term care plans and in resident’s documented progress records.A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Isolation precautions have been recently implemented. The resident and family interviewed advised they were kept well informed, and care continued to be provided in a timely manner. Staff and visitors suffering from infectious diseases are requested not to enter the facility. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs displayed in the facility. Gloves and gowns are accessible to staff.Residents and staff are offered annual influenza vaccinations. Other vaccinations are offered by the general practitioner where indicated. These are provided by an external vaccinator or a practice nurse from the applicable GP’s practice. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The nurse manager is well supported by the registered nurses. The GP, registered nurses and health care assistants interviewed demonstrated good knowledge of infection prevention and control policies and processes. On several occasions throughout the audit good hand washing techniques were observed. Where applicable advice is sought from the general practitioner, laboratory services, wound care nurse specialists, or the infection prevention and control nurse specialists at the DHB. A community based infection prevention and control nurse has also provided the nurse manager with advice and support when required, and an example of this was discussed. The nurse manager attends ongoing relevant education. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Infection prevention and control policy sets out the expectations the organisation and facility uses to minimise infections. This is supported by an infection control manual and policies and procedures (most were reviewed in 2018), that support specific areas including but not limited to wound management, cleaning and disinfection, laundry and standard precautions, transmission based precautions, blood and body fluid exposure prevention and management, single use items, and hand hygiene. Staff were observed demonstrating safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The registered nurses and caregivers interviewed could demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Infection control in-service education is held and is facilitated by the nurse manager with support of the external nurse specialists. Resident and family education is provided as and when appropriate. |
| 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 | All care staff are required to assist with surveillance activities and communicate to the registered nurses or enrolled nurse residents at risk of infection. Monitoring is discussed in meetings to reduce and minimise risk and to ensure residents’ safety. The nurse manager provides a monthly surveillance report. The service monitors respiratory infections, wounds, skin/soft tissue, urinary tract infections and gastroenteritis. The monthly analysis of infections includes comparison with the previous month, reason for the increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff meetings and where appropriate with family/residents. Overall monthly statistics remain low for the size and services provided at the facility. A targeted programme has been implemented which has reduced the incidents of urinary tract infections. This is an area of continuous improvement. Short and long term care plans were evidenced to document interventions to reduce and minimise the risk of infections and manage invasive devices.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There were no residents using restraints or enablers during the audit. The NM reported that restraint has never been used and the intention is not to use restraint. The NM reported if a resident required some sort of restraint an extra staff member would ‘special’ the resident. The restraint coordinator is one of the RNs and demonstrated good knowledge relating to restraint processes. The restraint/enabler register is available if required. The policies and procedures have definitions of restraints and enablers. Staff demonstrated knowledge about restraints and enablers and knew the difference between the two. The restraint/enablers forms part of the quality meetings. Restraint/enablers is also an agenda item at staff meetings. Meeting minutes and staff confirmed this. |

# 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)** |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | Staff files evidenced completed application forms, appointment letters, employment agreements, confidentiality statements, house rules and acceptable behaviour in the workforce. Reference checks were not evidenced and police vetting prior to employment has not been undertake. The NM reported police vetting has not been part of the recruitment process and that the service has recently started requesting the information from the Police. | None of the staff files reviewed evidenced reference checks and police vetting. | Provide evidence of police vetting and reference checking for all potential employees. 90 days |
| Criterion 1.2.7.4New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | An orientation programme was evidenced in three of the eight staff files reviewed. The programme covers all the essential components for the service. A completed orientation programme was not evidenced in five of the eight staff files reviewed. Staff interviewed reported they have received an orientation and the NM reported some staff have been working in the service for many years and the orientation documents may have been archived. | Not all staff files reviewed had evidence of a completed orientation. | Provide evidence that all staff have completed an orientation programme.90 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 Moderate | There is a system in place for ongoing education and staff interviewed demonstrated good knowledge. The education programmes for 2018 and 2019 lacked detail of what education has been provided. For example, the NM reported that medication management would have included pain management, however this was unable to be verified. The auditor could not ascertain from the programmes and the individual attendance records for staff what exactly has been provided. For example, there was no evidence of ongoing training around the Code and abuse and neglect. A number of required subjects were last provided in 2016, including but not limited to falls, continence, sexuality and intimacy training. Individual records showed there are staff who have not attended many of the sessions provided.All RNs and the EN have received on-going education on medicine management. Registered nurses were observed administering medicines safely during the audit and medication errors are low. Review of the files evidenced four of the five RNs and the EN do not have a current competency assessment. Two RNs and the EN last completed a competency in 2017, one RN in 2016 and the other RN in 2015. It is noted that during the audit, the NM started the process of assessing competencies. | (i)The education programmes do not provide enough details as to content; (ii) individual attendance records evidenced staff are not attending all training provided; (iii) there is no evidence of required education having been provided with some subjects last provided in 2016; (iv) medication competencies for registered staff are not all current. | Provide evidence of: (i) an education programme that includes all required subjects; (ii) individual records that evidence staff have attended all required sessions and training is on-going; (iii) all staff responsible for medicine management have current competencies. 30 days |
| Criterion 1.2.9.10All records pertaining to individual consumer service delivery are integrated. | PA Moderate | Information is recorded into residents’ files by the general practitioners, allied staff and registered / enrolled nurses. The records included the results of investigations and specialist consultations. Health care assistants (HCA’s) do not document in residents’ records. Health care assistants are documenting aspects of care during the morning shift on a ‘daily report sheet for caregivers’. This information includes but is not limited to hygiene cares provided, linen changing, oral cares and lotions applied. This information is utilised as a handover tool to the registered nurses and the nurse manager advised that it is intended that this information be regularly summarised by the RN/EN in the progress notes. This is no consistently occurring, and this information is not being consistently integrated into the residents’ individual files. The ‘daily report sheet for caregivers’ documents are being destroyed after approximately three months with information available only from early October 2018. The frequency of entries/progress notes in residents’ records is variable. Refer to criterion 1.3.3.3.Residents’ vital signs and weights are checked at least monthly. The results are entered onto a summary record that contains all residents’ data. This information is not consistently integrated into the individual residents’ records sampled, although the results are referenced during care plan evaluations.The daily bowel management record is maintained for designated residents. This contains information related to multiple residents. The information was not consistently included in individual residents’ files sampled. | Information on residents’ vital signs, weights and bowel management are recorded on summary sheets that contains information on multiple residents. This information, along with the summary of care provided by health care assistants during the morning shift is not consistently recorded and integrated into individual residents’ records sampled. The daily report for caregivers is being destroyed after approximately three months. | Ensure all resident related information is integrated into individual resident’s clinical records and held for the required period of time to comply with legislation.60 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | The registered nurses interviewed advised initial assessments are conducted and initial care plans developed within 24 hours of admission. These were present in sampled files. Consent forms are reviewed and completed. An admission agreement is signed by the resident or family member. New residents are required to be reviewed within five days of admission (if stable), by a general practitioner or nurse practitioner if not seen prior to admission. The resident is able to keep their own GP or change to a doctor or nurse practitioner at one of the three local practices that are currently providing regular services. InterRAI assessments have not been conducted within 21 days of admission, or at times subsequently every six months as there has only been one RN trained to undertake these assessments prior to December 2018 (refer to 1.3.4). The long term care plans have not been consistently developed within 21 days. These are reported to be developed based on clinical observation, feedback from care staff, the previous interRAI assessment and resident / family input. Regular evaluations have occurred to assess the resident’s progress towards meeting their goals. The long term care plans are reviewed at least every six months or sooner where indicated and details strategies to maintain and promote the resident`s independence, wellbeing and where appropriate their community involvement. Short term care plans are used where required. Residents are reviewed by the general practitioner or nurse practitioner at least every three months and sooner when applicable. Reviews of medicines occur three monthly with the electronic records identifying when these are next due. An annual multi-disciplinary review includes input from the resident/family, nursing staff (with input from the health care assistants and activities staff), the general practitioner and a pharmacist.Laboratory and other results, and outcomes from specialist appointments were in the residents’ files sampled.Nursing staff are required to document in residents’ files. Whilst sampled files contained documentation about changing residents’ health needs, incidents and family/visitors, on occasions, there were intervals of between four and 10 days with no documentation in all except one of the sampled residents’ notes. Health care assistants are documenting aspects of care on a ‘daily report sheet for caregivers’. This information is being utilised as a handover tool and the contents are not consistently integrated into the residents’ individual records. (Refer to 1.2.9.10).  | InterRAI assessments are not being consistently conducted within 21 days of admission, as noted in five of six applicable files sampled. InterRAI re-assessments are not being consistently conducted at least every six months as observed in two out of four applicable files sampled. Initial long term care plans have not been developed within 21 days in three out of six applicable files sampled. There are gaps in documentation in individual residents’ notes of between four and ten days. | Ensure interRAI assessments are conducted within 21 days of admission, and at least every six months or sooner if the resident’s condition changes and are used to inform the care plan. Ensure the initial long term care plan is developed within 21 days of admission. Ensure progress notes are consistently documented in a timelier manner.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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 3.5.7Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | The surveillance programme is appropriate to the services provided in this rest home. Data is reported and collated monthly with a focus being on minimising the spread of infection and reducing infection rates were able. A targeted programme to reduce urinary tract infections commenced in February 2017, in response to the numbers of urinary tract infections reported in 2016. | A targeted programme to reduce urinary tract infections and manage resident hydration is ongoing. This commenced in February 2017 and includes staff education, identifying residents at risk of urinary tract infection, management of ‘at risk’ residents’ fluid intake, offering a variety of beverages throughout the day (with the exception of residents where this is clinically contraindicated), and maintaining fluid balance charts where clinically indicated to ensure an individual resident’s fluid intake is within acceptable limits. Urinary tract infection rates were reported and monitored monthly. The surveillance data demonstrates a significant reduction in the number of urinary tract infections reported in 2017, with a further reduction in 2018. |

End of the report.