# MorningView Health Care Limited - Rose Garden Rest Home

## Introduction

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

The audit has been conducted by Q-Audit 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:** MorningView Health Care Limited

**Premises audited:** Rose Garden Rest Home

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

**Dates of audit:** Start date: 2 July 2019 End date: 3 July 2019

**Proposed changes to current services (if any):** Reconfigured 12 beds dementia unit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 20

# 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

Rose Garden Rest Home provides rest home care for up to 28 residents and has a special dispensation granted to cater for one hospital level of care resident. There were 19 residents assessed as rest home level of care and one hospital level of care at the time of the audit. The service is privately operated by two directors and managed by an experienced facility manager.

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The partial provisional audit was included to establish the level of preparedness of the provider to reconfigure the service to have 12 dementia level of care beds in the Tui House building.

The audit process for both the certification and partial provisional audits included observation of the environment, interviews with the staff, residents, families and management team. A review of documented processes was undertaken to ensure these are appropriate for the employment, orientation and training of staff to provide rest home and specialist dementia care.

Rest home areas requiring improvement relate to worn out toilet seats in lodge 3. The partial provisional audit of the proposed dementia unit identified that improvements are required to employing staff for the dementia unit and to elements of the environment.

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

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There is no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

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

## Organisational management

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

The two owner/directors are responsible for the service provided and are involved daily. A business plan and quality and risk management plan are documented and include the scope, direction, goals, values and mission statement of the organisation. A suitable transition plan for reopening and staffing the dementia unit is in place. The owner/directors demonstrated understanding of the requirements of providing dementia care. Systems are in place for monitoring the services provided, including regular reporting by the facility manager to the owners.

The facility manager is an experienced and suitably qualified registered nurse with knowledge of caring for residents with dementia. A quality and risk management system are in place which includes an annual calendar of internal audit activity, monitoring of any complaints and incidents, health and safety, infection control, restraint minimisation and resident/representative/family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported with discussion of any trends and follow-up where necessary. Adverse events are documented and are used as an opportunity for improvement.

The owner/director and the facility manager are aware of external notification requirements. Corrective action plans are being developed, implemented, monitored and signed off. Any feedback is used to improve services. Risks are identified and management strategies in place. The hazard register is up to date. A suite of policies and procedures based on current good practice cover all aspects of service delivery, are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. An orientation and staff training programme ensures that staff are competent to undertake their roles. A systematic approach to identify, plan facilitate and record ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster for staff to contact senior personnel afterhours for assistance and advice if needed.

Staffing requirements for the proposed dementia unit have been identified and advertising has commenced. Personnel are already on staff with appropriate experience and qualifications to care for residents with dementia. Additional staff are to be engaged prior to the unit reopening.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained using integrated hard copy files.

## 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. |  | Standards applicable to this service fully attained. |

The facility manager and registered nurse (RN) are responsible for the development of care plans with input from residents, staff and family member representatives. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems as they arise. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated.

The planned activity programme provides residents with a variety of individual and group activities and maintains links with the community. Medicines are safely managed and administered by staff with current medication administration competencies. All medications are reviewed by the general practitioner (GP) every three months or when required.

Nutritious meals, snacks and fluids are provided in line with recognised nutritional guidelines. Residents who require special or modified meals are reliably catered for. Snacks and drinks are available 24 hours for residents if needed in both rest home and proposed dementia unit.

## 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 low risk. |

The environment and buildings are fit for the care of residents at rest home level, are clean and well maintained. There is a current building warrant of fitness in place and current approved evacuation plan. The dementia unit is suitable for residents requiring secure care. Maintenance requirements are met for the lodges. Improvements are required to ensure that minor maintenance issues in the dementia unit are completed prior to the reopening. There have been no building alterations since the previous audit.

Functional, electrical and calibration checks of equipment and appliances are up to date. Clinical and household equipment and furnishings are in good order and sufficient for the number of residents. Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures

are regularly practised. Families reported a timely staff response to call bells. There is an intercom for communication between the lodges and the dementia unit.

The facility has adequate communal areas to meet the residents’ needs. All bedrooms are single. There are sufficient numbers of toilets and bathing facilities in the adjacent areas. Lights and call bells are installed in each bed space and bathrooms. The interior and individual spaces are maintained at a comfortable temperature. Family/whanau reported they felt their family member was safe and secure. Cleaning, waste management and laundry areas are secure.

There are two secure outdoor gardens for the use of residents and families. Pathways are level and paved. There have been no changes to the layout of the facility since the last audit.

## 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 RN is the restraint coordinator. The organisation has policies and procedures that support the minimisation of restraint. Ongoing restraint and challenging behaviour training are provided. There were no residents using enablers nor restraint at the time of the audit. The proposed dementia unit is secure and safe for residents.

## 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 control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

## 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 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 3 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Rose Garden Rest Home has developed policies, procedures and processes to meet its obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and ongoing training was verified in the training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident’s record. Staff were observed to gain consent for day to day care. The facility manager stated that residents are encouraged to have an enduring power of attorney (EPOA) enacted and that will include those who are going to be admitted in the dementia unit. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | As part of the admission process, residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family members and residents interviewed were aware of the Advocacy Service, how to access this and their right to have support persons. The FM and staff provided examples of the involvement of Advocacy Services in relation to residents’ care. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Residents and family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of the Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint. The service aims to acknowledge the complaint in five working days and outcomes are to be reported in 10 working days. If more time is needed reason for delay is noted.  The complaints register reviewed showed that complaints have been received over the previous year and this year and actions were taken through to an agreed resolution, are documented and completed in a prompt manner. Action plans show any required follow up and improvements that have been made where possible. The facility manager is responsible for complaint management and follow up and advised there has been only one complaint investigation by the DHB and this was not upheld. No complaints have been investigated by the Ministry of Health (MOH), Health and Disability Commission (HDC) Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility. All staff and family/whanau interviewed confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and Nationwide Health and Disability Advocacy Services during admission and discussion with staff. The Code is displayed at the reception area and around the facility together with information on advocacy services and how to make a complaint and feedback forms.  Resident information booklet was in place. Signed residents’ agreements were sighted in records reviewed. Service agreements meet the requirements of this standard and district health board requirements. Monthly residents’ meetings are conducted. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | 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 maintaining privacy throughout the audit days. All residents have a private room. Residents are encouraged to maintain their independence by engaging in regular exercises. Care plans reviewed included documentation related to the residents’ abilities and strategies to maximise independence. Records reviewed confirmed that each resident’s individual cultural, religious, social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. The reconfigured 12 bedded dementia unit have safe external areas that encourages purposeful walking. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. Staff support residents in the service who identify as Maori to integrate their cultural values and beliefs. There were residents who identify as Maori and care plans reflected all their cultural needs. Local cultural groups are consulted for advice. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. Family/whanau interviewed reported that staff acknowledge and respect their individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Evidence:  Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident. Residents and family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents’ personal preferences and special needs were included in care plans reviewed. The resident/family satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. Management representatives stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Facility manager and registered nurse attend regular educational training offered by the local district health board. Staff are enrolled into the online dementia course offered by University of Tasmania in Australia in preparation for the opening of the reconfigured 12 beds dementia unit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required as all resident were conversant with the English language. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Morning View Rest Home is licensed for 40 residential care beds housed in three conjoined lodges totalling 28 beds and a separate lodge of 12 beds. The 12-bed lodge was a dementia unit but has been used for private accommodation since 2015. The owners have notified the DHB that they wish to reopen the dementia unit in September 2019.The service holds contracts with the DHB for the provision of rest home care, respite services, long term care and care for young persons with a physical disability (YPD). On the day of audit there were 20 residents in the conjoined lodges. 19 had ARC rest home level contracts and one had dispensation for hospital level care. There were no ACC or YPD residents at time of audit.  The directors/owners govern the organisation and work in the business providing administration, human resources and environmental management. One owner is a qualified civil engineer and project manager and has worked as a healthcare assistant in a dementia unit. The other owner is a qualified accountant and is currently training to be a diversional therapist. The owner/directors were interviewed and confirmed a good understanding of the aged care sector, regulatory and reporting requirements. They maintain current management knowledge through attending training at the district health board (DHB) and/or industry conferences and update days.  The mission, philosophy and strategic goals of the facility are person-centred, documented in the business plan and reviewed annually. The current business plan includes a transition plan for reopening the dementia unit. Evidence of progress is maintained in the minutes of monthly management team meetings.  Day to day operation of the facility is the responsibility of the facility manager (FM) who was appointed in 2017 and is a registered nurse with a current practicing certificate. The FM has previous experience in advanced clinical care and management of aged care facilities including a dementia unit. The facility manager has completed ongoing relevant training in nursing and management and has recently completed an online specialist dementia care certificate with the University of Tasmania. Organisational performance is monitored by monthly management team meetings. |
| 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 | Day to day operation of the facility is the responsibility of the facility manager (FM) who was appointed in 2017 and is a registered nurse with a current practicing certificate. The FM has previous experience in advanced clinical care and management of aged care facilities including a dementia unit. The facility manager has completed ongoing relevant training in nursing, leadership and management, maintains current InterRAI assessment competencies and has recently completed an online specialist dementia care certificate with the University of Tasmania. Organisational performance is monitored by monthly management team meetings. A sample of reports were reviewed and showed adequate information to monitor performance is reported including any emerging risks or issues.  The FM is supported by the residential care officer (RCO) The RCO is a registered nurse in China, has a Level 5 certificate in health care studies and is a Career Force Assessor. A delegation system is in place to cover absences with the management team deputising for each other. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Quality and risk management plans and systems support service delivery. Achievement towards quality goals is measured. The management team interacts daily and has a formal meeting monthly. The health and safety system meet regulatory requirements. Hazard management and monitoring processes are in place. Adverse events and complaints are managed in accord with documented policy and the requirements of the Code. The FM and the owner are aware of mandatory notification requirements. Internal audits are conducted, and results used to inform improvements to services. Collated quality and risk data are providing full analysis on trends and themes. The required policies and procedures are documented, reviewed at least biennially and controlled, including guidelines for care of residents with dementia. Quality improvement activities are monitored and communicated throughout the facility. |
| 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 | There is a documented policy and process for managing incidents, accidents and near misses. All such events or near misses are recorded on an incident form and reported through the FM, to the owner/directors. A random sample of incident forms showed that they are fully documented. Incidents are investigated, action plans developed, and actions followed up in a timely manner. Family communications are noted in resident files. Adverse events data is collated, analysed and reported to the management team at the management meeting and to staff at the staff meetings. Meeting minutes sampled show discussion has occurred regarding any trends identified, action plans and improvements made at the staff meetings.  Policy and procedures described notification reporting requirements. The owner/director, FM and RCO are well informed on the responsibilities involved. There have been no notifications to external agencies since the last 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 Low | Certification Audit: FA  A documented HR policy defines the processes for recruitment and employment of staff in accord with MOH guidelines. Policies and procedures are in line with good employer practice and relevant legislation. Job descriptions sampled were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of work visa, qualifications and practising certificates (APCs), where required. A random sample of records confirmed the organisation`s policies are being consistently implemented and records are systematically maintained. Registered nurse and doctor credentials are current.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from the managers, registered nurse and health care team leader. Staff records sampled show documentation of completed orientation and a performance review completed annually.  Continuing education is planned on an annual basis. Mandatory education requirements are defined and scheduled to occur annually. On-line training programs are available. Care staff have either completed or commenced a New Zealand Qualification Authority education programme or equivalent to meet the requirements for the provider`s agreement with the DHB. The RCO is a trained Career Force Assessor. Five of the 14 staff currently have dementia training. All other staff are being enrolled in an online dementia course with the University of Tasmania, to be completed prior to the reopening of Tui House.  The FM and the registered nurse are fully trained interRAI assessors. Time is allocated for interRAI assessments to be completed. Education records reviewed demonstrated completion of the required training.  All staff who administer medications have current verification of their competencies. All staff have first aid certificates.  Partial Provisional Audit: PA  The orientation program includes provision for inclusion of the proposed dementia unit. As current staff transfer over and the new staff are employed  they will complete the dementia unit orientation. This is planned to be completed prior to the opening of the unit but has not yet commenced. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | Certification Audit:  There is a documented staffing rationale that meets the requirements of the ARC Contract. A sample of three rosters over the last 6 months confirmed adequate staff cover has been provided. No bureau staff are used. Staff can request a change, and this is recorded on the roster. Rosters and staff and family interviews indicated that there are adequate numbers of skilled staff on duty around the clock. This includes a minimum of two care staff in the lodge’s morning and afternoon and one at night. Rostered staff numbers remain the same over the seven days. Additional assistance is provided as needed by the FM who is a registered nurse, the RCO who is a registered nurse in China and one owner / director who also has care giving experience. Advice and assistance are available after hours within 10 minutes from designated on-call staff.  Partial Provisional Audit: PA  A staffing plan for the dementia unit identifies the additional staff that will be required in accord with the requirements of the ARC Contract. Allowance has been made for staff to escort residents going out in the van and to the doctor. Tui House will always have its own complement of staff with a separate roster allowing one care giver on duty at all times with additional assistance during the day and at night as required.  Recruitment advertising has commenced for another registered nurse with dementia care experience, another activities assistant with experience of providing activities for residents with dementia and more healthcare assistants with the intent of being fully staffed before the dementia unit opens. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The facility records all admissions, transfers in, discharges and to where in an electronic register. New information and updates are entered as they occur. All residents have a hard copy file. All resident records are integrated with allied health providers documenting their entries in a separate location in the integrated folder. Clinical records are documented daily, with additional entries as required and from the registered nurse. All records sampled were signed and designated. All records are securely stored. Paper records are held in a locked office accessible staff at any time. Old records are retained for 10 years and held in a secure archive site in the Cloud.  Review of resident files confirmed that the records are legible, and the name and designation of the provider are identifiable. A copy of the current care plan signed by the family and the RN is kept in a locked cabinet at the nurses’ station which is also locked when unattended. Files are not taken off site. Electronic information is protected by individual password with an automatic log-out function after a period of inactivity. The E-System is automatically backed up daily and record held in a secure location off site. Guidelines for access to resident files are provided in the confidentiality agreement signed by all staff on employment. Legal access by others, such as police, health providers, is defined. |
| 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 entry to the service policy includes requirements and procedures to be followed when a consumer is admitted to the service. All resident files reviewed had the appropriate needs assessments prior to admission to the service. Screening processes are clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. The enduring power of attorney (EPOA) of each resident was in place in files sampled. Admission agreements reflect all the contractual requirements. Families and residents reported that the admission agreements were discussed with them in detail. Details of the services location and hours, how the service is accessed and the process if a resident requires a change in the care provided, is also included. |
| 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, with an escort. The service uses the DHB’s (yellow envelope) system to facilitate transfer residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition appropriate information is provided to the person/facility responsible for the ongoing management of the resident. All referrals are recorded in the progress notes. |
| 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 system is implemented to ensure that residents receive medicines in a secure and timely manner that meets current legislation, protocols and guidelines. An electronic management system is used in administration, reviewing, and e-prescribing. The service uses a pre-packed medication system. All medication packs are checked by the RN on delivery against medication charts every month. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. GP conducts three monthly reviews of medication charts.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks. Medication is safely stored in locked cupboards and drug trolley. There were no expired medications on site. The RN was observed administering medication correctly. All staff who administer medicines were assessed as competent and evidence was sighted. There are no residents who self-administer medications at the service. Self-administration policy is in place for use when required. The FM and RN are prepared to manage the medication management for the rest home, hospital level of care residents including those in the proposed reconfigured 12 beds dementia unit. There is adequate storage for medicines and an extra drug trolley was sighted in the dementia unit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Meal services are prepared on site and served in the allocated dining room and residents’ rooms as required. The service employs cooks seven days a week. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four weekly rotating winter and summer menu in place. The Food Control Plan was approved on XXX  The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the service. Hot, cold drinks and snacks are available over the 24-hour period. Meals are served warm in sizeable potions required by residents and any alternatives are offered as required. The residents’ weights are monitored monthly and supplements are provided to residents with identified weight loss issues.  The residents and family interviewed acknowledged satisfaction with the food service.  The kitchen and pantry were sighted and observed to be clean, tidy and well stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.  Partial Provisional Audit:  The kitchen in the proposed dementia unit is already in use as the kitchen for the rest home. Appliances and storage are sufficient for the additional meal preparation that will be required. The cook reported that the food service will be able to accommodate and cater for the additional 12 residents in the dementia unit. |
| 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 | There is a documented policy on decline of entry to the service. When a consumer’s entry to the service is declined, the resident/whanau are referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, consumer and their family or advocate in a timely and compassionate manner. Where requested, assistance would be given to provide the consumer and their family with other options for alternative health care arrangements or residential services. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Prior to admission, residents have their level of care identified through a needs assessment by the Needs Assessment and Service Coordination (NASC) agency. The FM and RN utilises standardised assessment tools to gather information regarding the resident, in consultation with the resident and their relatives where appropriate. Files sampled contained appropriate completed assessment tools and interRAI assessments were reviewed at least six monthly or when there is a change to a resident’s health condition. Cultural, sexuality and intimacy needs have been identified for the residents. Additional assessments were completed according to the need e.g. including nutritional, continence and pressure assessments. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whanau present where possible.  A medical assessment is undertaken within five days of admission and reviewed as a resident's condition changes, or three monthly. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| 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 provided to residents met assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed as per policy. Monthly observations are completed and are up to date. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents’ needs. Staff confirmed they have access to the supplies and products they needed. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Activities are planned by the diversional therapist (DT) who is also the director in consultation with the activities coordinator. A monthly planner is posted on the notice board and resident rooms. Activities assessments are completed on admission. The activities provided at the service take into consideration residents’ interests and ability. Residents and their family/whanau are consulted in the activities assessment and planning process. There is a wide range of activities offered: including bingo; quiz; music sessions; walking; movies through Netflix; art and craft. There is community involvement with external entertainers invited, church and music groups. Residents are either taken out as a group or individually. Attendance list is completed daily, and documentation was sighted. Evaluation of the individual activity plans are completed every six months.  The DT reported that a 24-hour dementia care plan will be developed for all residents in the dementia unit and the current activities coordinator has level six health and wellbeing qualification. Further online dementia course will be completed. All necessary equipment for games was sighted and more will be provided as reported by the DT. The DT attends monthly diversional therapist meetings for the Northland region. The reconfigured 12 beds dementia unit have adequate space for residents to conduct their activities. The service won a Gold Award in the 2018 Northland Rest Home Olympics. Residents’ meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the day of the audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau, residents and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed, signed and closed out when the short-term problem has resolved. |
| 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 | There is a documented process for the management of all referrals. Residents are supported to access or seek referral to other health and/ or disability service providers. The service utilises a standard referral form when referring residents to other service providers. Copies of referrals were sighted in residents’ files reviewed. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the RN or GP. |
| 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 | Guidelines for the management of waste and hazardous substances are documented. All waste and hazardous substances (cleaning chemicals) are stored safely. Domestic and biohazardous waste is removed as per council requirements. Personal protective equipment is available. Staff receive education on the management of waste and hazardous substances and waste management audits are completed.  Partial Provisional Audit Tui House:  The guidelines for the management of waste and hazardous substances will be implemented in Tui House. Secure storage is provided for waste and cleaning chemicals. Current processes for removal of domestic and biohazardous waste and for related audits will be extended to include Tui House. Personal protective equipment is available. Staff education and waste management audits will be extended to include Tui House. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | Certification Audit: FA  The facility comprises three conjoined lodges, all facilities have been well maintained and are fit for purpose. There are living and dining areas in each lodge. The communal areas are adequate for the number of residents. Handrails are installed in all passageways and bathrooms. There is level access to all areas. The furniture and fittings have been well maintained. Vinyl and carpet floor coverings are in good condition. External areas are level and paved. There is open access to a fenced external garden for the three conjoined lodges with a pathway that circumnavigates the garden. There is a separate enclosed and secure garden with high fencing, suitable seating and shelter where residents are safe from traffic in the grounds.  Staff report that there is sufficient equipment and supplies for resident care on the lodges. Measuring equipment is calibrated annually. Electrical testing and tagging have been completed on all electrical equipment and appliances. There is a system for identifying any maintenance requirements as they occur. Improvement is required to ensure that minor repairs in Tui House are addressed prior to reopening the facility. There is a hazard identification process and a risk, hazard and emergency response plan. Environmental audits are conducted. The current building warrant of fitness for all buildings expires on1/5/20.  There is a nine-seater van for outings with current warrant of fitness, registration, pull-out steps and a separate step and handrail for ease of access. There is a documented process regarding transportation of residents. Escorts are provided in accord with the supervision needs of the residents. There is a first aid kit in the van. All seats have seat belts. All staff who drive the van have current licenses.  There is a current approved fire evacuation plan. There have been no changes to the layout of the buildings that has required the approved evacuation scheme to be amended.  Partial Provisional Audit Tui House:PA  The separate 12-bedroom Tui House was previously a dementia unit. The House has not been used for residential care for three years but has been well maintained and used for private accommodation. The owners propose to reopen the dementia unit in October 2019. The house has a living and dining area with a second adjoining lounge area suitable for activities. Handrails are installed in all passageways and bathrooms. There is level access to all areas. The furniture and fittings have been well maintained. Vinyl and carpet floor coverings are in good condition. External areas are level and paved. Tui House has a separate enclosed and secure garden with high fencing, suitable seating and shelter. External decks in the dementia unit have high security screens enabling residents to see the views but preventing falls from the decks.  The transition plan includes the purchase of additional equipment and supplies for Tui House but these have yet to be obtained. Improvement is required to ensure that minor repairs in Tui House are addressed prior to reopening the facility. There is a hazard identification process and a risk, hazard and emergency response plan. Environmental audits are conducted. The current building warrant of fitness expires on1/5/20.  There is a nine-seater van for outings with current warrant of fitness, registration, pull-out steps and a separate step and handrail for ease of access. There is a documented process regarding transportation of residents. Escorts will be provided in accord with the supervision needs of the residents and allowance has been made in the transition plan staffing numbers for this. There is a first aid kit in the van. All seats have seat belts. All staff who drive the van have current licenses.  The current approved fire evacuation plan includes Tui House. Assurance was sighted from the Fire Service on audit day that the plan does not need to be revised when Tui House reopens. There have been no changes to the layout of the buildings that has required the approved evacuation scheme to be amended. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Certification Audit: FA  There are sufficient conveniently located single toilets and showers throughout the lodges. All showers are well maintained. There are reversible privacy locks on toilets and showers. Separate visitor and staff facilities are available. Some resident rooms have a shared ensuite or a hand basin and hand washing gel dispenser. Hot water temperatures in resident areas are monitored monthly and records indicate safe temperatures are maintained.  Partial Provisional Audit Tui House: FA  There are sufficient conveniently located single toilets and showers throughout Tui House. All showers have ventilation, heating, handrails and are well maintained. There are reversible privacy locks on toilets and showers. Separate visitor and staff facilities are available. Some resident rooms have a hand basin and hand washing gel dispenser. Hot water temperatures in resident areas are within safe parameters. Provision has been made to monitor hot water temperatures monthly. |
| 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 | Certification Audit: FA  All bedrooms are single occupancy. Two twin rooms in the lodge are currently used as single bedrooms. Rooms are well maintained, are decorated with personal possessions and are of sufficient size to enable use of walkers or wheelchairs if required. All rooms have external windows with limited opening brackets installed. All rooms receive natural sunlight at some time during the day.  Partial Provisional Audit: FA  All bedrooms are single occupancy and furnished with a bed, bed light, call bell, side table, chair, chest of drawers and either a built in or free-standing wardrobe. Rooms are of sufficient size to enable use of walkers or wheelchairs if required. All rooms have external windows with limited opening brackets installed. All rooms receive natural sunlight at some time during the day. . |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Certification Audit: FA  Communal areas consist of a large lounge and a dining area in each lodge. Communal areas are of a sufficient size to accommodate all residents. There is adequate room for activities. There are secure outdoor areas furnished with tables and chairs. All residents have access to a garden area safe from traffic in the grounds.  Partial Provisional Audit:FA  There is a large communal lounge and dining area and a second lounge suitable for activities. These areas are of a sufficient size to accommodate 12 residents. There is a are secure outdoor deck furnished with tables and chairs. A high trellis prevents falls from the deck. All residents have access to a garden area safe from traffic in the grounds. There is a safe enclosed walking route around the corridors, decks and garden. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Certification Audit: FA  Cleaning and laundry tasks are included in the job descriptions of the health care assistants (HCAs). Cleaning and laundry procedures are documented. Personal protective equipment and clothing is provided. The staff confirmed that cleaning and laundry equipment is sufficient to meet the needs of residents. There are designated secure areas for laundry and cleaning appliances and activities. Laundry chemicals are dispensed from fixed containers. Cleaning chemicals are labelled, and material data safety sheets were sighted. All laundry is washed on site. The laundry is separated into clean and dirty areas. The large domestic washers and dryers are in good working order. Laundry can be dried outside. Cleaning and laundry staff have received education regarding the use of chemicals which is conducted by the chemical provider. HCAs were able to describe infection control practices. HCAs also confirmed that they had sufficient time to do cleaning and laundry without compromising their care giving duties. Cleaning and laundry services are monitored through resident / family feedback and internal audits with good results.  Partial Provisional Audit: FA  Cleaning and laundry tasks are included in the job descriptions of the health care assistants (HCAs). Cleaning and laundry procedures are documented. Inspection on site confirmed that personal protective equipment and clothing is provided, and that cleaning and laundry equipment is sufficient to meet the needs of residents. There are designated secure areas for laundry and cleaning appliances and activities. Laundry chemicals are dispensed from fixed containers. Cleaning chemicals are labelled, and material data safety sheets were sighted. All laundry will be washed on site. The laundry is separated into clean and dirty areas. The large domestic washers and dryers are in good working order. Laundry can be dried outside. Education regarding the use of chemicals is included in the orientation programme and is conducted by the chemical provider. There is a process for monitoring the effectiveness of cleaning and laundry through the internal audit process and resident / family feedback. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Certification Audit and Partial Provisional Audit Tui House:  There is an approved fire evacuation plan date 19/9/13. The plan includes the three lodges and Tui House. There have been no changes to the buildings since then. Trial evacuations are conducted every six months and records are maintained. There are fire extinguishers throughout the building. Regular inspections to support the building warrant of fitness are documented.  There is an emergency and disaster response plan which covers a range of emergencies. There is sufficient equipment, extra blankets, food and clinical supplies and water for at least three days stored on site in the event of an emergency or if the mains supply fails. There is emergency lighting on battery for four hours, electric torches and extra batteries. The kitchen hobs are run on LPG. There is also a gas barbecue for cooking. There are first aid supplies and all staff have completed first aid training. There are sufficient continence pads and toilet paper for three days. Additional infection control supplies for a pandemic are stored on site. All resident bed spaces and communal areas have call bells, including toilets and showers. There is an intercom system between the lodge and Tui House. The level of support each resident would need in the event of an emergency is documented in their care plan. Lateral evacuation between the lodges or from Tui House to the lodges would be activated until alternative accommodation was arranged if required.  The three lodges are interconnected with several clearly marked level exits in each building. All exits allow free egress but require keys or codes to enter from the outside. External doors and windows are checked each evening and monthly security checklist are completed to ensure the facility always remains safe and secure. Families interviewed confirmed that they felt their resident was safe and secure. There are two clearly marked level exits in Tui House. |
| 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 | Certification Audit: FA  Every resident bedroom and all communal areas in the lodges have natural light and ventilation. Heating is provided through wall radiators in every room. There are two residents who smoke. A designated safe external area is provided for smokers.  Partial Provisional Audit Tui House:  Every resident bedroom and all communal areas in Tui House have natural light and ventilation. Heating is provided through wall radiators in every room. A designated safe external area is provided for smokers. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually through an annual report with trend analysis and has goals for the upcoming year.  A registered nurse is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the senior management through the integrated quality meeting.  The infection control manual provides guidance for staff about how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.  There are family meetings that cover aspects of infection control and if they are unwell, it is recommended that they do not visit the service. During higher risk times of community infections and winter months notices are placed at the door to remind people not to visit if they are unwell, there is sanitising hand gel at the entrance and throughout the service. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has appropriate skills, knowledge and qualifications for the role. The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standards and current accepted good practice. Policies and procedure were reviewed. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. The ICC attended an infection prevention and control training conducted by the local district health board. A record of attendance is maintained and was sighted. The training education is detailed and meets best practice and guidelines. Residents are reminded on infection control practices during residents’ meetings or as when required. External contact resources include: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. New infections and any required management plans are discussed at handover, to ensure early interventions occurs. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. Surveillance programme is reviewed during the infection control programme review. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The organisation is committed to prompting a restraint free environment and to provide the staff with good guidelines to enable them to prevent the need for restraint. Restraint is only used as a last resort and staff receive adequate training to enable them to make informed decisions. All staff receive education regarding restraint minimisation and management of challenging behaviours. Staff interviewed were clear regarding the difference between a restraint and enabler use. The service currently has no residents using restraint or enablers. A restraint register is in place if needed. The environment for the reconfigured 12 beds dementia unit is secure. |

# 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 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The facility orientation program includes provision for inclusion of the proposed dementia unit. As current staff transfer over and the new staff are employed for the dementia unit, they will complete the dementia unit orientation. This is planned to be completed prior to the opening of the unit but has not yet commenced. | The dementia unit orientation program has not yet been implemented. | Implement the dementia unit orientation program prior to occupancy as new staff are employed.  Prior to occupancy days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | A staffing plan for the dementia unit identifies the additional staff that will be required in accord with the requirements of the ARC Contract. Allowance has been made for staff to escort residents going out in the van and to the doctor. Tui House will always have its own complement of staff with a separate roster allowing one care giver on duty at all times with additional assistance during the day and at night as required.  Recruitment advertising has commenced for another registered nurse with dementia care experience, another activities assistant with experience of providing activities for residents with dementia and more healthcare assistants with the intent of being fully staffed before the dementia unit opens. | Staffing for the dementia unit is not yet complete. | Acquire sufficient appropriately experienced staff for the dementia unit prior to occupancy.  Prior to occupancy days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The power point connections for the panel radiators in the bedrooms in Tui House bedrooms are installed at knee height and not protected from interference.  Ranch slider doorways in both the lodges and Tui House have raised tracks that pose a trip hazard.  The paint is wearing off the bases of two toilets in Tui House. The bowls are badly stained.  The surface of the seats of toilets 05 and 06 in the lodge have deteriorated and are pealing.  Bathrooms do not have privacy curtains.  Additional medical equipment has not yet been purchased for Tui House. | Provide protection for the low set power point connections of the radiators in the bedrooms in Tui House to prevent interference from inquisitive residents.  Install mini ramps to prevent tripping over the ranch slider tracks.  Paint the bases of two toilets in Tui House and clean the bowls to ensure that infection control is maintained.  Replace the toilet seats in toilets 05 and 06 in the lodge.  Install shower curtains in the bathrooms to maintain privacy if the door is opened while a resident is showering.  Obtain sufficient medical equipment for Tui House prior to opening day. | Provide evidence that maintenance has been updated prior to reopening Tui House.  60 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.