# North Health Limited - Rose Garden Rest Home

## Introduction

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

The audit has been conducted by 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:** North Health Limited

**Premises audited:** Rose Garden Rest Home

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

**Dates of audit:** Start date: 27 October 2020 End date: 28 October 2020

**Proposed changes to current services (if any):** Change of ownership.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 27

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

Rose Garden Rest Home provides rest home and dementia level care for up to 40 residents. The facility is operated by MorningView Health Care Limited. The service is managed by a facility manager who is a registered nurse.

This provisional audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, the owners and a general practitioner.

The audit also established how well prepared the prospective provider is to provide a health and disability service. The prospective owners were interviewed during this audit. The prospective provider understands the Health and Disability Standards and the Age Residential Related Care Agreement.

Fifteen improvements are required from this audit and relate to; the non-restraint policy, satisfaction surveys, analysis of quality data and feedback, corrective actions, hazard register, observations following falls, currency of practising certificates, position descriptions for specific roles, food safety, restraint training, currency of special dispensation for a resident, medication reviews, fridge and medication room temperatures, medicine management, menu and special diet reviews, odour in the dementia unit, general maintenance of the facility in areas both internal and external including worn linen, aerial cords, hot water supply, safe decking, safe heating, maintained gardens and lawns.

## Consumer rights

The facility manager is responsible for the management of complaints and a complaints register is current. There have been investigations by the District health Board since the previous audit.

Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer 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 are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged.

## Organisational management

Morning View Health Care Limited is the governing body and is responsible for the service provided. A business and quality and risk management plan includes a mission statement, philosophy, business direction, objectives and an organisational chart. The owners are on site each day and have close contact with the facility manager.

The service is managed by an experienced facility manager who is a registered nurse. The manager is supported by the owners.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms are completed, and quality data evidenced some analysis and corrective action plans being developed, implemented, monitored and signed off as being completed to address the issue/s that required improvement. Staff and residents’ meetings are held.

Policies and procedures on human resources management are in place and processes are followed. In-service education has been provided and staff performance is monitored.

A documented rationale for determining staffing levels and skill mixes is in place. Senior health care assistants, the facility manager and the owners are on call after hours.

## Continuum of service delivery

Residents are assessed prior to entry to the service to confirm their level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by the facility manager (FM) and the registered nurse (RN). Twenty-four hour activities care plans are in place for residents in the secure dementia unit. InterRAI assessments and individualised care plans were sighted.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP). The organisation uses an electronic medication management system. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Snacks and drinks are available 24 hours for residents if needed in both rest home and the dementia unit. A food control plan was in place.

## Safe and appropriate environment

A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Single accommodation is provided with some rooms sharing a full ensuite and some rooms with a wash hand basin. Adequate numbers of additional bathrooms and toilets are available. There are lounges, dining areas and alcoves. External areas for sitting and shading are provided.

Security and systems are in place. Residents and families reported timely responses to call bells.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is undertaken on site and both cleaning and laundry is evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly.

## Restraint minimisation and safe practice

No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. There were no residents using restraint. Documentation included assessment, approval, monitoring and individual evaluation processes should these be needed. Staff interviewed demonstrated knowledge and understanding of restraint minimisation and safe practice.

## Infection prevention and control

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.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 37 | 0 | 3 | 5 | 0 | 0 |
| **Criteria** | 0 | 78 | 0 | 7 | 8 | 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 policies and procedures that meet their 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 and ongoing training is provided. |
| 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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation’s standard consent form. These are signed by the enduring power of attorney (EPOA) and the general practitioner makes a clinically based decision on resuscitation authorisation. All files sampled had activated EPOA in the dementia wing. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members’ lives. |
| 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 and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national 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 facility manager 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. 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 facility manager (FM) is responsible for the management of complaints. The complaints forms and associated documents meet the requirements of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Information on the complaint process is provided to residents and families on admission and was available throughout the facilities. Residents and families reported they knew how to make a complaint.  The complaints register evidenced six complaints have been received since the previous audit and that actions taken through to an agreed resolution were documented and processes completed within the timeframes required. Action plans showed any required actions or improvements that have been made where possible. staff interviewed confirmed an understanding of the complaint process and what actions are required.  There have been four complaint investigations by the DHB since the previous audit. The complaints relate to resident care, the environment both internal and external and behaviours that challenge. Documentation reviewed indicated there are continuing concerns. A review has been undertaken by the DHB since the previous audit and a report dated the 20 October 2020 has five recommendations, two of which have been addressed prior to this audit relating to employing another RN and repair of a broken window in room 2. One of the remaining three recommendations relating to the odour in room 19 was closed at this audit. The other two remain open relating to the dementia unit decking and heating in all areas. (Refer to criterions 1.4.2.6 & 1.4.8.1)  The auditors were advised of a fifth complaint during the audit, received by the DHB on the 23 October 2020 concerning the care of a resident. The DHB requested the resident concerned be one of the resident tracers undertaken. (refer to standard 1.3.3) |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members and residents interviewed were aware of consumers rights and confirmed that information was provided to them during the admission process.  The information pack outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.  In interview conducted the prospective owners demonstrated a good understanding of the consumers rights (the code) that they must adhered to. The prospective owners currently operates other rest home facilities. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ privacy and dignity are respected. Staff were observed maintaining privacy. Residents were supported to maintain their independence with the residents able to come and go within the building. There is a secure garden area outside for residents, however they do not frequent the area independently and none of the residents were observed outside on the audit days (Refer 1.4.2.6). Records sampled confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The facility manager reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice. |
| 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 | The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings were conducted when and as required. All staff receive cultural awareness training. There were five residents who identify as Maori at the time of the audit. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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 family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members interviewed confirmed they were encouraged to be involved in the development of the long-term care plans. Residents’ personal preferences and special needs were included in care plans sampled. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family members and residents 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. The facility manager 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 study days offered by the local district health board. Staff are enrolled in career force training and some have completed the online dementia course offered by University of Tasmania in Australia. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members stated they were kept well informed about any changes to 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.  Staff know how to access interpreter services if required. 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 | MorningView Health Care Limited is responsible for the services provided. A business plan 2019-2020 was reviewed and included a mission statement, philosophy, business direction and objectives. The business plan is reviewed annually by the owners. An organisational chart was also sighted.  The facility manager is an RN and has been in the position for three years. The FM has also managed another aged care facility prior to this position. The owners have experience in management and one is a diversional therapist. The owners are responsible for some of the non-clinical activities.  Interview of the FM and review of their file evidenced appropriate ongoing education and a current practising certificate.  The owners work in the facility and the FM and owners reported they have daily ‘catch ups’ and discuss all the activities concerning the facility. During the Covid 19 lockdown the owners and FM took part in zoom meetings with the DHB.  The prospective provider, North Health Limited, consists of two owners, one is an RN and the other is experienced in business. The prospective provider has experience in the aged care sector and currently owns and manages two other aged care facilities.  A comprehensive transition plan was reviewed. Interview with the prospective provider and the current owners demonstrated that the current owners are committed to providing a handover during the transition period, until February 2021, when the prospective provider reported they intend to take ownership. The prospective provider’s comprehensive business plan and quality and risk plans were also reviewed.  The prospective provider stated they are yet to decide which staff will be offered new contracts. The prospective provider will provide support to the clinical team. The current owners reported they have notified the District Health Board prior to the provisional audit being undertaken. The prospective provider reported they have also met with the District Health Board prior to the audit.  Occupancy on the first day of the audit was 27 residents. Twenty-four were assessed under the age-related residential care contract (12 rest home, 1 hospital level and 11 dementia & 1 resident under the long-term chronic health conditions contract). Two residents were under the residential respite care contract. |
| 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 | When the FM is absent, the RN covers the clinical aspects of the service with support from the senior health care assistant (HCA). If the owners are away, the senior HCA takes responsibility for non-clinical matters including arranging contractors if required.  The prospective provider understood the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | The quality and risk management plan guides the quality programme. An internal audit programme is in place and audits have been completed for 2020 as per the audit programme.  Quality improvement data included adverse event forms, internal audits, meeting minutes, infection rates and health and safety. There was documented evidence that quality improvement data is being collected and collated. Analysis of quality data including infections mainly consisted of numbers.  Corrective action plans were evidenced following the completion of audits and incident/accidents, however, there was little documented evidence relating to whether the action was effective and closed out. Minutes documented who is responsible for corrective actions, however, timeframes for the completion was not documented. Deficits identified in the resident meeting minutes did not evidence any corrective actions. Resident/family satisfaction surveys have not been completed for two years.  Staff and resident meetings are being held during 2020 apart from the lockdown period during Covid-19 when memos and texts were provided to staff using the ‘WhatsApp’. Meeting minutes evidenced reporting quality data back to staff is mostly numbers of clinical indicators including infections.  Relevant standards are identified and included in the policies and procedures. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly. Staff confirmed they were advised of updated policies and that they provided appropriate guidance for service delivery. Obsolete documentation is filed electronically. Although the facility has a policy titled ‘Non Restraint Policy’, the policy has contradicting information in the body of the policy.  Health and safety policies are available. A hazard register was not available, and staff do not document hazards they observe. The FM who is the health and safety representative reported staff report any hazards verbally and the FM and owners address it. Staff confirmed they advise the FM of any hazards.  The prospective provider advised the policies and procedures will stay in place initially and intend to introduce an electronic system including policies and procedures. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | Staff are documenting adverse, unplanned or untoward events on accident/incident forms which the FM reviews. An adverse event monthly analysis is completed by the FM. An adverse event register documents each individual event, the date and a description. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Incident/accident reports for residents who have experienced an unwitnessed fall evidenced inadequate timeframes around neurological observations.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Families confirmed they are advised in a timely manner following adverse events or change in their relative’s condition.  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 FM advised there have been four essential notification made to the Ministry of Health since the previous audit. Documentation reviewed confirmed this.  There are no known legislative or compliance issues impacting on the service. The prospective provider is aware of all current health and safety legislative requirements and the need to comply with these. |
| 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 | Policies and procedures relating to human resources management are in place. Staff files included job descriptions, apart from the restraint and infection control coordinators, which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments for medication management, education records and police vetting.  An education programme is the responsibility of the FM. The programme for 2020 evidenced in-service education is provided at least monthly. Staff reported they discuss specific topics relating to resident’s health status at handover. Individual records of education and contents of each session are held on file and electronically. Competencies were current for medicine administration. The FM is interRAI trained and has a current competency. The HCAs that handle food have not completed education relating to food safety. Restraint training has not been provided.  A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. The facility currently uses an external assessor. All HCAs have either completed or completing dementia specific training, and new staff are enrolled. The HCAs stated they found the understanding dementia programme provided by the University of Tasmania to be very informative.  An orientation/induction programme is in place. The entire orientation process, including completion of competencies, takes up to a month to complete and staff performance is reviewed and annually thereafter. Orientation for staff covers all essential components of the service provided.  Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice apart from the dietitian and the podiatrist.  Staff confirmed they have completed an orientation, including competency assessments and on-going training is provided at least monthly. |
| 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. The rosters are the responsibility of the owners and they reported they review the rosters continuously and consider dependency levels of residents and the physical environment. Registered nurse cover is provided seven days a week with the new RN working the weekends and rostered on the morning and afternoon shifts as per the roster. The FM/RN works Mondays to Fridays. Both RNs are full time. The RN has been working in the facility for three weeks and was registered in NZ in April 2020. Review of their CV evidenced the RN was first registered overseas some years ago. The RN is based in the dementia unit. In the dementia unit there are two HCAs on the morning shift, two on the afternoon shift and one on the night shift. In the rest home is are two HCAs on the morning shift, two on the afternoon shift and one the night shift. All HCAs are responsible for the cleaning and laundry as part of their role. The owners reported a contractor carries out a deep clean of the facilities once a week. Activities are provided by an enthusiastic activity’s person and one of the owners who is a diversional therapist. The senior HCA, the FM/RN and the owners are on call after hours. Any short falls are filled by the HCAs who want to work more hours. Care staff interviewed reported they are ‘very happy’ with staffing levels and easily get through their work. They reported the FM is very supportive.  The prospective provider understood the required skill mix to ensure rest home and dementia residents needs are met. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | A resident register is maintained of all current and past residents. Resident individual information is kept in paper and electronic format. The resident’s name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents’ information. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled. Clinical notes were current and integrated with GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.  Archived records were held securely onsite and were readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 service policy includes all the required aspects on the management of enquiries and entry. Rose Garden Rest Home’s welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Residents in the secure dementia unit were all admitted with consent from the EPOA.  Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families were involved in all exit or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| 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. | PA Moderate | The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A senior HCA was observed administering medicines safely and correctly. The medication and associated documentation are in place. Medication errors were analysed and corrective actions implemented as required. There were no residents self-administering medications and there is a self-administering policy in place if required.  An improvement is required relating to monitoring of fridge, medicine room temperature and documenting outcomes of pro re nata (PRN) medicines. |
| 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. | PA Low | There is an approved food plan for the service. Meal services are prepared on site and served in the allocated dining room. There is a four-weekly rotating winter and summer meal in place.  Meals are served warm in sizeable portions 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. Snacks and drinks are available for residents who wake up during the night. The residents and family members interviewed acknowledged satisfaction with the food service. Residents’ meetings were conducted where any concerns about food were discussed. (Refer 1.2.3.8).  The chefs has completed food handling training, however other staff who involved in handling food have not completed education relating to food safety (Refer 1.2.7.5). The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.  An improvement is required relating to a menu review by the dietitian and updating residents’ diet profiles during care plan reviews. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The FM reported that all consumers who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | Residents have their level of care identified through needs assessment by NASC agency. Initial assessments were completed within the required time frame on admission while resident care plans and interRAI are completed within three weeks according to policy. Subsequent six monthly interRAI assessments were completed and were current.  An improvement is required to ensure there is a current special dispensation in place for resident assessed as hospital level of care. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents’ goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. The individual behaviour management plans specified prevention-based strategies for minimising episodes of challenging behaviours and described how the residents’ behaviour was best managed over a 24-hour period. Family/whanau interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents such as the mental health services for older people, district nurses, dietitian and GP. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Interventions were adequate to address identified needs in the care plans. Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input was sought in a timely manner, that medical orders were followed, and care was person centred. Health care assistants confirmed that care was provided as outlined in the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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 | The planned activities are appropriate to the residents’ needs and abilities. The activities were based on assessment and reflect the residents’ social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Social and recreational assessments were completed within two weeks of admission in consultation with the family/whanau. The activities were conducted mostly separately in the rest home and secure dementia unit and these were conducted by the activities coordinator with oversight from the owner/director who is an experienced qualified diversional therapist (DT). The DT in consultation with the FM and senior HCA are involved in developing a monthly planner which is posted on the notice boards and given to all residents. The activities are varied and appropriate for rest home level of care residents and residents living with dementia and are offered from Monday to Sunday.  Twenty-four hour activities care plans were in place and were sighted in all files sampled in the secure dementia unit. Residents’ files have a documented diversional therapy care plan that reflects their preferred activities of choice and were evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members interviewed reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is documented on each shift by care staff in the progress notes. The FM and RN document weekly or as necessary. All noted changes by the health care assistants were reported to the nursing staff in a timely manner.  Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occur every six months or as residents’ needs change. These were carried out by either the FM and RN in conjunction with family, GP and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan.  Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau were included and informed of all changes. |
| 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 and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, RN or FM sends a referral to seek specialist service provider assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurse, FM or the GP. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals were attended to and the resident transferred to public hospital in an ambulance if required. |
| 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 | Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted throughout the facility and accessible for staff.  Protective clothing and equipment were sighted in the laundries that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | A letter from the local authority reviewed advised when the current building warrant of fitness expired in August 2020 a compliance schedule was issued that expires in May 2021 due to the Covid 19 lock down. This is displayed at the front entrance. Residents confirmed they can move freely around the facility and that the accommodation meets their needs.  Observation of the facilities, interviews of residents and families and review of documentation evidenced a number of findings relating to the physical environment both internally and externally. The odour problem in room 19, from the DHB review was not evident on the days of the audit. However, the dementia unit smelt of urine on both days of the audit. Carpet is lifting in one of the passageways in the rest home and fittings are dated and worn. Laundry supplies are low and looked worn out.  There is a proactive and reactive maintenance programme. Maintenance is mainly undertaken by one of the owners. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current.  External areas are available. The outside area for residents in the dementia unit is secure with seating and shade, however, residents were not observed going out there during the audit. The railing around the decking outside the dementia unit has been raised, however the potential for residents to climb over remains. This does not allow residents to safely access the decking independently. The gardens are the rest home are full of weeds and the lawns were long. The buildings have areas where the paint has peeled off and TV cords were observed coming out of some resident’s windows, along the side of the building to the aerial on the roof.  Care staff confirmed they have access to equipment, that equipment is checked before use and they are competent to use it.  The prospective provider stated they have plans to refurbish the facilities in stages and are considering providing a dementia service only. |
| 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 | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Four bedrooms share an ensuite between two rooms and some have a wash hand basin. There are additional toilets and showers in close proximity to the residents’ rooms. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas. Separate bathrooms for staff and visitors are available. |
| 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 | There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photographs and other personal items on display. Bedrooms are large enough for residents and staff with equipment to manoeuvre within.  There is adequate room in the facility to store mobility aids such as mobility scooters, wheelchairs and walkers. |
| 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 | Communal areas are available for residents to frequent. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy. The furniture in the lounges and dining rooms is appropriate to the setting and residents’ needs.  There is adequate space to accommodate wheelchairs in the dining room and lounges if required. |
| 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 | All laundry is washed and dried on site. The laundries have clean and dirty flows. Staff demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen. Residents and families interviewed reported the personal clothes are mostly managed effectively and returned in a timely manner. There are separate named baskets for each individual resident.  The facility is cleaned to an adequate standard. Staff have received appropriate training including training from the chemical company representative who visits monthly. Chemicals are stored in a lockable cupboard and were in appropriately labelled refillable containers. The cleaning trolleys are stored in locked rooms when not in use |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The current fire evacuation plan was approved by the New Zealand Fire Service on the 19 September 2013. A fire evacuation drill takes place six monthly with a copy sent to the New Zealand Fire Service. The last fire drill was held on the 18 September 2020. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.  Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are also displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency.  Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage meets the requirements for the emergency water storage recommendations for the region. Emergency lighting is battery powered. These resources are regularly tested, and recordings were validated. A call bell system is available, and residents and families reported they are answered in a timely manner. Observations during the audit confirmed this.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the facilities checked by staff. The rest home and the dementia unit have a system connecting the two should staff need to connect the other facility.  The services emergency plan considers the special needs of people with dementia in an emergency. |
| 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. | PA Moderate | Residents are provided with safe ventilation and natural light. Residents and families reported the temperature during the winter months was cold. On audit days the temperature was in the mid-twenties and residents started it was comfortable. Heating is provided by heat pumps and electric heaters. At least half of the resident’s bedrooms are not provided with any sort of permanent means of heating. The owners stated the heaters have been removed for servicing.  There is a covered external area 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 | Rose Garden Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The FM is the infection control coordinator (ICC). They have access to external specialist advice from the GP, infection control consultant and DHB infection control specialists when required. A documented role description for the ICC was not in place (Refer 1.2.7.3).  The infection control and prevention programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control and prevention programme is appropriate for the size and complexity of the service.  There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There has been no infection outbreak since the last audit. Covid-19 information is in place and all MOH requirements were being followed. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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 FM 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 management quality meetings and monthly 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 organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. 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 facility manager and other specialist consultants. The facility manager attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The infection control and prevention information is detailed and meets best practice and guidelines. External contact resources included the GP, laboratories, infection control consultant 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 collated and analysis of data is rudimentary and mainly consists of numbers (Refer 1.2.3.6). Staff interviewed reported that they are informed of infection rates at monthly staff meetings. 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. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service demonstrated that the use of restraint is actively minimised. Restraint has not been used for five years and there were no residents using an enabler. Enablers were the least restrictive and used voluntarily at the residents’ requests. The restraint coordinator is the FM and demonstrated good knowledge relating to restraint minimisation, however restraint training has not been provided to staff. The FM and owners stated Rose Garden Rest Home is a restraint free environment. The facility has a policy titled ‘Non-Restraint Policy’ and restraint has not been used since the owners took ownership the facility five years ago, however, the policy contradicts the title. The information in the policy is about the use of restraint and the process for using restraint if required. The policy has definitions of restraints and enablers (refer to criterion 1.2.3.3) Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies and procedures were available and are reviewed and updated two yearly. Staff confirmed they were advised of updated policies and that they provided appropriate guidance for service delivery. They are able to access all policies electronically and have hard copies of the clinical policies to refer to in the nurses’ station. Obsolete documentation is filed electronically. The facility has a policy titled ‘Non-Restraint Policy’, and the owners reported the facility is a restraint free environment. Restraint has not been used since the owners took ownership the facility five years ago, however, the policy contradicts the title. The information in the policy is about the use of restraint and the process for using restraint if required. | The non-restraint policy title and the restraint free environment status contradicts the information in the actual policy and procedure. | Amend the non-restraint policy so that it reflects that Rose Garden is a restraint free environment and restraint is not used.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data included adverse event forms, internal audits, meeting minutes, infection rates and health and safety. There was documented evidence that quality improvement data is being collected and collated. Analysis of quality data including infections mainly consists of numbers. Analysis did evidence whether falls are witnessed or unwitnessed. However, there was no evidence of any trends. Staff meeting minutes evidenced reporting back to staff is mostly numbers and was word for word from the analysis. Care staff interviewed stated they do discuss corrective actions at the staff meetings and the FM confirmed this, however the minutes do not evidence this. A resident/family satisfaction survey was not available, and the FM stated one hasn’t been completed since 2018. | Analysis of quality data is rudimentary and consists mainly of numbers. Although staff and the FM confirmed quality data is reported back to them at staff meetings, minutes of meetings did not reflect this. Satisfaction surveys have not been consistently undertaken. | Provide evidence that (i) quality data is comprehensively analysed with trends identified and meeting minutes reflect reporting back to staff, (ii)resident/family satisfaction surveys are conducted in a regular basis.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | There was evidence of corrective action plans when deficits are identified following the completion of audits and incident/accidents. There was little documented evidence relating to whether the action was implemented, whether it was effective and closed out. Staff meeting minutes document who is responsible for corrective actions, however, timeframes for the completion of the action is not documented. Deficits identified in the resident meeting minutes did not evidence any corrective actions. A continuing theme in the residents meeting minutes evidenced residents are making suggestions relating to what they would like to eat. There was no evidence in the following months minutes that this had been addressed with the cook. Residents and families stated they make suggestions about what they would like, however, nothing happens. | Although corrective actions were evidenced, there is no evidence around implementation and effectiveness. Staff meeting minutes evidenced corrective actions and who is responsible, however timeframes are not documented. Resident meeting minutes do not evidence corrective actions. | Provide evidence that (i) corrective actions have been implemented and reviewed for effectiveness and closed out, (ii) timeframes are documented in the staff meeting minutes for completion of corrective actions and (iii)resident meetings include corrective actions relating to all deficits identified and this is reported back to residents in their meetings.  90 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Moderate | A business risk management plan was reviewed and includes a wide range of risks associated with the business. Health and safety policies are in place. A hazard register was not available to identify potential and actual hazards and staff do not document hazards they observe on hazard forms. The FM who is the health and safety representative reported staff report any hazards verbally and the FM and owners then address it. Staff confirmed they advise the FM of any hazards. (Refer criterion 1.4.2.4) | A hazard register was not available, and staff are not documenting any hazards they identify. | Provide evidence of a hazard register that includes potential and actual hazards.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Adverse, unplanned or untoward events are being documented on accident/incident forms by the care staff. The FM is responsible for reviewing all the forms, any investigations and corrective actions. The FM documents all adverse events on a monthly analysis register. An adverse event register documents each individual event, the date and a description of the event. Documentation reviewed and interviews of staff indicated appropriate management of adverse events apart from neurological observations following unwitnessed falls. Incident/accident forms evidenced neurological observations are taken only once. | Review of incident/accident forms evidenced residents who experience an unwitnessed fall have neurological observations taken once only. | Provide evidence that care staff are following best practice guidelines for the timeframes around the taking of neurological observations.  7 days |
| Criterion 1.2.7.2  Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | Current practising certificates were evidenced for the FM/RN, the RN, pharmacist and GPs. The practising certificates for the podiatrist who visits and the dietitian who reviews the facility’s menus were not current. | The practising certificates for the dietitian and podiatrist are not current. | Provide evidence that current practising certificates are held on file for all staff and contractors who require them.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Human resources management systems are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments for medication management, education records and police vetting.  Review of the FMs file evidenced job descriptions for restraint and infection control coordinator are not on file. | Position descriptions for restraint coordinator and infection control coordinator were not evidenced in the FMs file. | Provide evidence that the restraint coordinator and infection control coordinator have a copy of the position description on file.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Ongoing education for staff is provided at least monthly. The programme for 2020 evidenced all core subjects are provided. Educators come into the facility to take some sessions. Staff reported they discuss specific topics relating to resident’s health status at handover. Individual records of education and contents of each session are held on file and electronically. All HCAs have current competencies for medicine administration. The FM is interRAI trained and has a current competency. The HCAs that handle food have not completed education relating to food safety. Care staff have not been provided with restraint training. | The HCAs who manage the food service especially the evening meal have not completed education relating to food safety. Restraint training has not been provided. | Provide evidence that all staff who are involved in handling food have completed education relating to food safety.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Indications for use were noted on ‘as required’ medications, allergies were clearly indicated, and photos were current. Administration records were maintained, and drug incident forms were completed in the event of any drug errors. All medicines were reviewed every three months and as required by the GP. Medicines are prescribed by the GP and ordered from the pharmacy through the electronic medication management system. Medication reconciliation was conducted by the RN or FM when a resident was transferred back to service. The RNs checks medicines against the prescription. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. The controlled drug register was current and correct. Weekly stock takes were conducted, and six-monthly stock takes were completed by the pharmacist on the day of the audit. | Three medication charts have not been reviewed every three months according to policy requirements and there was no evidence of fridge and medicine room temperature monitoring. | Ensure three monthly medication reviews and monitoring of fridge and medicine room temperature are conducted.  90 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | The service uses an electronic medication system and each staff has a log in password to access and record medications administered, not administered, refused and with-held. Administered pro re nata (PRN) medication outcomes were not being documented for effectiveness. | Outcomes of (PRN) medications were not documented. | Provide evidence that effectiveness of PRN medication administered are documented.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Residents’ diet profiles were not being reviewed/updated at each care plan review and menu has not been reviewed by a registered dietitian. | The chef reported that they were reviewing menu seasonally. The summer menu currently in use has not been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. Documents confirming review of winter menu 25 June 2019 were sighted. Resident diet profiles were not being regularly reviewed/updated at each care plan review. | Ensure the menu is reviewed by the registered dietitian in a timely manner and resident diet profiles are updated at each care plan review.  180 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. Additional assessments were completed according to the need e.g. behavioural, nutritional, continence, skin and pressure assessments. The nursing staff utilise standardised risk assessment tools on admission. In interviews conducted family/whanau expressed satisfaction with the assessment process. The resident previously assessed as hospital level of care had no current special dispensation in place. Neurological observations were only being completed once post unwitnessed falls (Refer 1.2.4.3). | No current special dispensation completed for a resident assessed as hospital level of care with the last one completed in 2017. | Provide evidence of current special dispensation for resident assessed as hospital level of care.  90 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 Moderate | Residents were observed moving freely throughout the interior of the facilities. The internal environment is in need of refurbishing. Fittings are dated and look worn out. For example, there are wash hand basins that are stained and taps that don’t match each other. The dementia unit smelt of urine on both days of the audit, families interviewed confirmed this. In lodge 2 one of the two bathrooms has a protective corner broken near the shower exposing the material underneath. Wheelchairs turning into the toilet outside room 25 has stretched and lifted the carpet to the point where it is unsafe. The linen cupboards evidenced supplies of towels, face cloths and sheets are low and was observed to be worn and thin. The bedrooms with wash hand basins have no running hot water and the owners stated the hot water cylinder was removed prior to them taking ownership five years ago. Residents reported they do not like washing their face in cold water. Documentation evidenced hot water temperatures in the common toilets and showers are within the recommended range.  Externally there is paint peeling off areas and the wood is exposed underneath. Television aerial cords were observed leading out of resident’s windows to the main aerial on the roof. | (i)The dementia unit spelt of urine during the audit.  (ii) Maintenance is required in the lodge two bathroom.  (iii)Fittings are dated and worn.  (iv)the paint is peeling of the areas of the buildings externally  (v)supplies of linen is low and worn.  (vi)The carpet is lifting in the passageway outside room 25.  (vii)There is no hot water supplied to the bedrooms with a wash hand basin.  (viii)TV aerials are running along the outside of the building in the rest home from the resident’s windows to the roof. | Provide evidence that residents are provided with an appropriate, accessible physical environment and facilities that are fit for purpose.  90 days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Moderate | External areas are available. The outside area for residents in the dementia unit is secure with seating and shade, however, residents were not observed going out there during the audit. A family member and a resident raised this with the auditor. The owners stated they do go out there with a staff member and staff try and encourage residents to go outside on their own, but they are reluctant to do so. The railing around the decking outside the dementia unit has been raised, however the potential for residents to climb over remains. The owners stated the door to the decking is kept locked unless a staff member is with the residents. This does not allow residents to safely access the decking independently. The gardens around the rest home are full of weeds and the lawns are long. The owners stated the contractor comes once a month in the winter months and fortnightly in the summer months to mow the lawns and weed. | (i)The railing around the decking outside the dementia unit has been extended but is still not high enough.  (ii)The lawns around the rest home are long and the gardens need weeding. | Provide evidence that (i)the railing around the decking has been raised to a safe height, (ii)the lawns and gardens are maintained to an adequate standard.  90 days |
| Criterion 1.4.8.1  Areas used by consumers and service providers are ventilated and heated appropriately. | PA Moderate | The facilities were observed to be well ventilated on the days of audit. The temperature was comfortable in the facilities as the weather was mild, however, residents and families reported the temperature during the winter months in their bedrooms was cold and heating was inadequate. Heating in the common rooms of both facilities is by means of heat pumps and electric flat wall heats with fan heaters in the bathrooms. At least half of the resident’s bedrooms have no permanent means of heating. The heaters are fan oil filled heaters that are mobile, hot to touch and have no means of protection from residents being burnt. The heaters were observed in the garage and the owners stated they were there to be serviced. | Not all bedrooms have a permanent means of heating that is safe for residents. | Provide evidence that all residents bedrooms have a means of permanent heating that is safe for residents so that bedrooms are adequately heated.  90 days |

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

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

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

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

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End of the report.