

Beetham HealthCare Limited - Beetham Healthcare

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Beetham HealthCare Limited
Premises audited:	Beetham HealthCare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 19 June 2017 End date: 20 June 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	41

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Beetham HealthCare provides rest home, hospital and dementia care level care for up to 42 residents. On the days of audit there were 41 residents. The service is managed by a general manager who is supported by a clinical manager and a quality and human resources manager.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

The residents and relatives interviewed spoke positively about the care and support provided.

Improvements are required around interventions to meet the consumers' needs, service provider training and infection control coordinator training.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Beetham HealthCare practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends can visit at any time and ongoing involvement with community activity is supported. Complaints processes are being implemented and complaints and concerns are managed and documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The board of directors have strategic business and annual quality goals with quality objectives. Quality information is reported to monthly staff and management meetings. The service has ongoing quality projects to improve outcomes and service delivery for the residents. Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal audits and receive meeting minutes. The service has comprehensive policies/procedures to provide rest home, hospital and dementia levels of care. There is an orientation programme in place and an annual education programme in place that includes compulsory training for aged care staff. There are documented job descriptions for all positions, which detail each position's responsibilities,

accountabilities and authorities. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. There are registered nurses on duty 24 hours.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team covering seven days a week provide an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The programme meets the abilities and recreational needs of the groups of residents. The programme is varied and involved the relatives and community. There were 24-hour activity plans for residents in the dementia care unit that were individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed and reviewed by a dietitian who visits monthly. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. Systems and supplies are in place for essential, emergency and security services. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There were seven residents voluntarily using enablers and no restraint use on the day of audit.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator is responsible for coordinating and providing education and training for all staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	2	1	0	0
Criteria	0	90	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Beetham HealthCare practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and posters of the Code are displayed at the front entrance. The policy relating to the Code is implemented and staff interviewed (four registered nurses, three healthcare assistants and one diversional therapist) could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are policies in place for informed consent and the service is committed to meeting the requirements of the Code of Health and Disability Consumers Rights. There were signed general consents on all seven files sampled. The four registered nurses interviewed confirmed that family involvement occurs with the consent of the resident. Residents interviewed confirm that useful information was provided to them to make informed choices. Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives. Written directives are recorded for resuscitation status for six of seven files sampled (three from the hospital, two from the rest home and two from the dementia unit). In the seventh file, there was evidence of a discussion held but decision not made.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed in the front entrance of the facility. Healthcare assistants interviewed were aware of the residents' right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy. Residents have access to an advocate for health consumers who attends resident meetings on request.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service maintains key linkages with other community organisations. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends can visit at times that meet their needs. Families interviewed state they are always made to feel most welcome when they visit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy states that the facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Four of the management team have completed privacy training and are included in the investigation of complaints as relevant. There is a complaint register that includes relevant information regarding the complaint, acknowledgment within the required timeframe, investigation, outcomes, follow-up letters, offers of advocacy and resolution. There were eight complaints (six for 2016 and two for 2017 to date). Complaints information is in the information pack at entry. There were complaints forms and advocacy brochures available and a suggestions box at the front entrance. Management operate an open-door policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is available at reception. The facility manager or clinical manager discusses aspects of the Code with residents and their family on admission. Seven residents interviewed (four rest home and three hospital) and ten relatives (four rest home, four hospitals and two of dementia care residents) reported that the residents' rights are being upheld by the service. Residents and family members interviewed state they received sufficient verbal and written information to be able to make informed choices on matters that affect them.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Māori consultation is available through the cultural advisor for the service. The cultural advisor attends the staff meetings and provides education sessions for staff. Staff receive education on cultural awareness during their induction and at least two yearly. All healthcare assistants (HCAs) interviewed were aware of the importance of whānau in the delivery of care for Māori residents. There were no residents who identified as Māori on the day of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with healthcare assistants (HCAs) confirmed their understanding of professional boundaries, including the boundaries of the HCAs role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Healthcare assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Three HCAs and four registered nurses (RNs) could describe how they build a supportive relationship with each resident.</p>

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The board of directors and management team are committed to providing services of a high standard, based on the service philosophy of care. Staff were observed during the day demonstrating a very caring attitude to the residents. Residents interviewed state they are very happy with the level of care provided. The service has implemented policies and procedures that are developed and reviewed by a healthcare consultant. The policies and procedures meet legislative requirements. Staff receive a verbal handover between every shift that details any significant events.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry and any items they must pay for that is not covered by the agreement. The information pack is available and advised that this can be read to residents. Interpreter services are available as required. Relatives interviewed, stated that they are informed when their family member's health status changes. Nine incident/ accident forms reviewed all documented that families had been informed of incidents/ accidents. Discussions with HCAs and RNs identified their knowledge around open disclosure. Residents /family meetings are held every two months and have recently been changed to alternate weekdays and weekends allowing for more relatives to attend.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Beetham HealthCare is a 42-bed facility that provides rest home, hospital/medical and dementia level care. The service has 36 dual purpose beds hospital/rest home and a six bed secure dementia unit. Occupancy on the day of audit was 41 residents. There were six residents in the dementia unit and 35 residents in the dual purpose beds (seventeen rest home and eighteen hospital level). All residents were under the ARCC. There were no residents under medical services or respite care. Beetham Village and Beetham HealthCare are privately owned and governed by a board of directors. They employ a facility manager to operate both the village and the healthcare facility. The facility manager (non-clinical) has been in the role two and a half years and has management experience in the public service sector. She is supported by a full-time experienced clinical manager (CM) who has been in the role three years. A qualified quality and human resource manager supports the management team and coordinates staff education and quality systems. The facility manager reports directly to the two monthly board meetings. There is a three-year strategic business plan that contains the vision, mission and values for Beetham HealthCare. The business plan is reviewed regularly by the board. The service has annual quality goals objectives and measures

		<p>progress towards meeting the goals and objectives. Goals achieved for 2016 included above 80% resident/relative satisfaction from the annual survey. The service gained a second place at an aged care conference for small operator category in 2016.</p> <p>The facility manager has maintained at least eight hours of professional development annually including a three-day attendance at an aged care conference, two-day dementia conference and attending quarterly DHB forums.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>During a temporary absence, the clinical manager will cover the facility manager's role. A senior RN provides cover for the clinical manager leave. The service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There are organisational policies to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and internal audit schedule. Quality information and data is discussed at the monthly staff meetings including health and safety, infection control, audit outcomes and any concerns/complaints. Staff interviewed stated they are well informed and receive quality and risk management information such as a monthly adverse event summary. All events are entered in to the healthcare consultant's database and trended against industry key performance indicators. The HCAs interviewed state they are asked for suggestions and feedback on quality initiatives.</p> <p>An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed.</p> <p>The quality and risk management programme includes health and safety and hazard identification. Staff report any hazards identified on the relevant form. The service has a health and safety officer who completed an update to health and safety training in June 2016. An HCA who is the health and safety representative has completed stage one of the health and safety training. Health and safety and emergency management training is included in the one-day training plan. The hazard registers have</p>

		<p>been reviewed six-monthly with generic hazards and work area specific hazards.</p> <p>Falls prevention strategies are in place for individual residents that includes the analysis of falls and any areas for improvement.</p> <p>Satisfaction surveys completed annually are residents/relatives (September 2016) and a food survey in July 2016 (91% satisfaction). The survey results are collated to identify if there are any areas for improvement and fed back to participants.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>There is an accident/incident policy, which is part of the risk management plan. Monthly data collection of accident/incidents is completed. When an incident occurs, the staff member discovering the incident completes the accident/incident form. The incident/accident and progress notes evidence timely RN clinical assessment and identifies preventative and corrective actions. All incidents/accidents are signed off by the facility manager/clinical manager, who conducts a further investigation if required. Nine incident/accident forms for March 2017 evidenced detailed investigations and corrective action plans following incidents, however, neurological observations and risk alerts had not been followed up for five unwitnessed falls and one choking incident (link 1.3.6.1). There has been one section 31 notification to HealthCert and the DHB for a diagnosed subdural haematoma post unwitnessed fall.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (four HCAs, two RNs, one clinical manager and one cook). The recruitment and staff selection process requires that police vetting and reference checks are completed prior to employment to validate the individual's qualifications, experience and suitability for the role. All files evidence a signed employment contract and job description. Staff files reviewed had annual performance appraisals completed where due. Annual practicing certificates for RNs and allied health practitioners are all current. There is an orientation programme in place and staff are orientated to their area of work and complete competencies relevant to their role including medication and wound competencies. Housekeeping staff assist with meals, not all have been trained to safely manage this task.</p> <p>The quality/HR manager is a Careerforce assessor and coordinates training for all staff. A one-day training day covering mandatory training requirements commenced in 2017. Staff are allocated to attend the study day which is provided regularly to ensure all staff attend. Additional training includes manual handling with the physiotherapist and palliative care with the hospice. Competencies are identified and completed. Registered nurses and HCAs are encouraged and supported to undertake external education as offered.</p>

		<p>Eight HCAs are employed in the dementia unit. Five HCAs have completed the required dementia standards. Three HCAs have been employed less than 6 months and are registered to commence the dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Staffing rosters were sighted and evidenced that staff that are sick and staff on annual leave are replaced. There is a full-time clinical manager on Monday to Friday and on-call. There is a registered nurse on duty 24 hours who also oversees the care for the dementia unit residents. An HCA is on duty 24 a day in the dementia care unit with support provided from the rest home/hospital. There an integrated roster for the rest home and hospital beds; the morning shift, there are four HCAs on duty and one breakfast person/HCA from 7am to midday. Afternoon shifts are staffed with four HCAs on the full shift and one short shift. On night shift, there is one HCA with the RN in the rest home hospital.</p> <p>The facility manager/clinical manager are on duty Monday to Friday. There are dedicated laundry/cleaning staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a secure office in all areas. Care plans and notes are legible and signed and dated by the RN or HCA. Progress notes are completed for each shift and recorded in the nursing/care progress notes form held in the residents file.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack for residents being admitted to the dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy.</p> <p>The admission agreement reviewed aligns with the service's contracts. Seven of seven admission agreements viewed were signed.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation is completed by an RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior care staff who administer medications have been assessed for competency on an annual basis. Registered nurses and care staff interviewed could describe their role in regard to medicine administration. Education around safe medication administration has been provided and audits undertaken including by pharmacy.</p> <p>Standing orders are not used. Three self-medicating residents had been assessed by the GP and RN as competent to self-administer and these had been reviewed three-monthly.</p> <p>Fourteen medication charts over the three levels of care were reviewed. The medication profiles reviewed were legible, up-to-date and reviewed at least three monthly by the GP. All medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service employs a qualified chef who is supported by a cook and kitchen staff. All staff have been trained in food safety and chemical safety. There is a five weekly, four season's menu that had been designed by the dietitian who visits monthly. The menu was currently being reviewed with the last review being June 2015. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as vegetarian and pureed/soft and gluten free meals are provided. Food is plated in the kitchen and delivered in three scan boxes (nine residents in the serviced apartments also receive meals). Fridge and freezer temperatures are checked daily. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits. The head chef maintains regular contact with residents.</p>
<p>Standard 1.3.2: Declining</p>	FA	<p>The service records the reason/s for declining service entry to potential residents should this occur and</p>

<p>Referral/Entry To Services</p> <p>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.</p>		<p>communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The facility has embedded the interRAI assessments within its clinical practice. InterRAI initial assessments and assessment summaries were evident in the files reviewed. Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. Additional assessments such as management of behaviour and wound care were completed according to need. In the resident files reviewed the outcomes of all assessments, needs and supports required were reflected in the care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans sampled were resident centred and support needs and interventions were documented. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were evaluated and reviewed on a regular basis.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/intern NP visit.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds. Wounds in the dementia care unit included two skin tears on one resident. There was a resident with a skin tear and another with a lesion at rest home level. Five residents between them had: four skin tears, two chronic wounds, one lesion and one moisture wound at hospital level. Adequate dressing supplies were sighted in the treatment room. There were no pressure injuries. Pressure injury prevention strategies were included in the long-term care plan of the residents at risk of pressure injuries. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p>

		Monitoring forms are in place to continually assess a resident's progress where there is a change in health status however, a shortfall was identified around neurological observations and the absence of a choking alert for one resident.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activity team (one diversional therapist and one activities officer covering seven days of the week) implement a separate activity programme for the rest home/hospital and dementia unit. With six residents in the dementia unit, the staff in the unit are involved in providing activities as per the programme. The programme has set activities, with flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group and they are gender appropriate. The residents are provided with a copy of the weeks activity programme along with the menu each week. The programme is displayed throughout the facility.</p> <p>Activities were observed to be delivered simultaneously in the rest home/hospital and dementia unit. Contact is made and one-on-one time is spent with residents who are unable, or chose not to participate in group activities. There are monthly outings/drives (using a contracted van) for all residents as appropriate. Entertainment and a visit from residents in other local residential care facilities occurs weekly along with other involvement in community events. On-site church services are held in the facility chapel/activity room. The programmes include visits by musicians, pets and from preschool and school children, exercise sessions and a range of intellectual, craft and fun activities. Residents in the dementia unit were observed to be involved in the programme including active participation in a baking session.</p> <p>Attendance logs and a record of individual resident's activities is kept. Activity staff complete two-weekly recreational progress and evaluation notes in the residents' files. The activity plan in the files reviewed had been evaluated at least six-monthly (more frequently when resident's condition indicated) with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan and a number of relatives actively participate.</p> <p>Resident/relative meetings are held bi-monthly with a number of the residents and relatives stating they attend. A quarterly newsletter is distributed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses' six monthly or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. There is at least a three-monthly review by the GP/intern NP. Family are notified when this is to occur and are welcome to attend (if resident agrees) and the GP/intern NP will discuss any issues with them. Family members interviewed confirmed they are invited to attend the</p>

		GP/intern NP visits and have input into the multidisciplinary reviews.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Referral to other health and disability services is evident in the sample group of resident files. Referral documentation is maintained on resident files. There was evidence in the files sampled of referrals to the DHB and input from, physiotherapist, dietitian, wound clinical nurse specialist, speech therapist and the intern nurse practitioner who will attend daily if required. The service facilitates access to other medical and non-medical services.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets were available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 9 July 2017.</p> <p>The facility employs a maintenance person to undertake maintenance and maintain the courtyard gardens. The village gardener cares for the remainder of the gardens and the village gardens. Daily maintenance requests are addressed and a 12-monthly planned maintenance schedule is in place. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. Contractors are available 24-hours for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids.</p> <p>Residents were observed to safely access the outdoor gardens and courtyards safely. Seating and shade is provided.</p>

		<p>The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The dementia care unit provided an open plan dining/lounge area with free and safe access to an outdoor courtyard with gardens, seating and shade, which had won a local award for an outdoor environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>All bedrooms are single occupancy and have ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has a large lounge/dining area for the rest home and hospital residents, which is divided into a number of areas for dining and seating is placed to allow for individual or group activities. There is a separate large activities room / chapel. There are seating alcoves throughout the facility. The communal areas are easily accessible. The dementia care unit has a spacious open plan dining/lounge area with seating placed appropriately to allow for low stimulus, small group and individual activities. The communal areas are easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And</p>	FA	<p>There are policies and procedures and audits of the cleaning and laundry service. The laundry has an</p>

<p>Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>entry and exit door with defined clean/dirty areas.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. There are adequate civil defence supplies including water and food storage. There is a battery backup in the event of a power failure and the service has a contract with a supplier for a generator in the event of a power failure.</p> <p>The fire evacuation scheme was approved by the fire service on 30 September 2009. There are six monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Security policies and procedures are documented and implemented by staff. The buildings are secure at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control coordinator/RN team leader. The infection control programme is reviewed annually by the IC coordinator and quality manager and reported to the facility manager and quality committee.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.</p>

and visitors. This shall be appropriate to the size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	PA Low	<p>The infection control coordinator last attended external education in February 2015. The service is affiliated with an external aged care consultant for any advice or updates for policies.</p> <p>The infection control coordinator provides monthly reports to management and staff meetings. The infection control coordinator has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, clinical wound nurse specialist, nurse practitioner, GPs and DHB wound nurse. She has not attended any infection control education within the last two years.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies (last reviewed by an aged care consultant in June 2017) link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the annual training programme. Staff are required to complete infection control questionnaires and hand hygiene audits.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place, that are appropriate to the complexity of service provided.</p> <p>Infection control data is discussed at the monthly meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule. The service is benchmarked against other similar services through the aged care consultant database.</p> <p>Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers, last reviewed June 2017. The service currently has no residents assessed as requiring the use of restraint and seven residents using enablers (bedrails). There is a restraint coordinator (clinical manager) who reports to the RN meetings and restraint committee. There is documented evidence of consultation with the resident and family/whānau regarding the use of enablers. Three resident files of those using enablers evidenced voluntary request and consent to enabler use.</p> <p>Staff receive training around restraint minimisation on orientation and as part of the annual education programme.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The cleaning roster identified that one cleaner was allocated to help feed hospital level residents at breakfast time. On three days of the week, the cleaner is also an HCA who has completed HCA orientation and is on duty as an HCA three-days a week. On the other week days, the cleaner assisting with hospital resident feeds, including residents with an identified risk of choking has not been trained in carrying out this resident related task (Household staff have only commenced assisting with meals in the past week).	One cleaner allocated to assist with resident feeds in the hospital has not received any training to carry out this duty. The risk is considered low as the practise was to cease immediately with a change in the roster to reflect that only care staff would feed the hospital level residents.	<p>Ensure staff carrying out residents' feeds have been trained to safely carry out the task.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are</p>	PA Moderate	Monitoring forms include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, pain monitoring, blood sugar levels and behaviour charts however	1) Five neurological observations post unwitnessed falls had not been completed as	1) Ensure neurological observations

<p>consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>neurological observations had not been completed as per protocol. One resident with a potential to choke did not have an alert on the file.</p>	<p>per policy. There was no pulse recorded for three of five neurological recordings. 2) One resident requiring first aid for a choking incident did not have the choking risk alert on file.</p>	<p>are completed as per protocol. 2) Ensure potential risks are identified on residents' files.</p> <p>60 days</p>
<p>Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.</p>	<p>PA Low</p>	<p>The infection control nurse has been in the role since 2014. She attended external infection control education in February 2015. The infection control coordinator provides annual infection control education to staff.</p>	<p>The infection control coordinator has not attended external education within the last two years.</p>	<p>Ensure the infection control coordinator attends external education to maintain own knowledge in infection control and prevention.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.