Parata Anglican Charitable Trust - Parata Anglican Charitable Trust

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:	Parata Anglican Charitable Trust Board
Premises audited:	Parata Anglican Charitable Trust
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 July 2017 End date: 27 July 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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

Parata Anglican Care rest home is a charitable trust governed by a board of trustees. The rest home provides care for up to 26 residents. On the day of audit, there were 26 residents.

The manager is an enrolled nurse with many years' experience in aged care management. She is supported by an assistant manager (also an enrolled nurse), two part-time registered nurses, an administrator and long serving staff.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff, management and two general practitioners (GPs).

Residents and family members interviewed praised the service for the support provided.

Improvements are required around medication management and care planning.

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.

The staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

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.		Standards applicable to this service fully attained.

Performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan and quality plan have goals documented. There are policies and procedures that provide appropriate support and care to residents with rest home level needs. This includes updates around interRAI requirements and a documented quality and risk management programme including analysis of data.

Ongoing training is provided and there is a training plan implemented for 2017. Rosters and interviews indicate sufficient staff that are appropriately skilled with flexibility of staffing around client's needs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the residents assessed needs and abilities and residents advised satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts had photo identification and allergy status documented.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with ensuite facilities. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There was one resident using a restraint (bed rail) and four residents using an enabler (bed loops).

The service has documented policies and procedures for restraint minimisation and practice. Policies and procedures include definition of restraint and enabler that are congruent with the standards. There is a restraint coordinator for the service, who is the registered nurse.

Infection prevention and control

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

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control nurse (the registered nurse). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends.

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	48	0	0	2	0	0
Criteria	0	99	0	0	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with staff (five caregivers, the registered nurse and the activities officer) confirmed their familiarity with the Code. Six residents and five family members interviewed confirmed the services being provided are in line with the Code.
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	Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. A multipurpose informed consent form is utilised by the service provider which was retained in each individual resident's record reviewed. Forms are signed and dated appropriately. The admission agreements have been signed and dated by the provider and the resident and/or representative. Two GPs interviewed understood the obligations and legislative requirement to ensure competency of residents for advance directives and advance care planning. Resident reviews were undertaken six-monthly. Reviews of the individual resident's health status was documented and retained in each personal file reviewed. There are policies in place for informed consent and resuscitation and the service is committed

		to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussion with residents confirmed that the service actively involves their relatives in decisions that affect their lives, where they consent to this.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions.
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 confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at reception. The residents interviewed were aware of the complaints process and to whom they should direct complaints. The service has had no complaints in 2016 to present date 2017. Residents and relatives interviewed advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that includes: the Code, complaints and advocacy. This information is also in formats suitable for people with intellectual disabilities. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents interviewed identified they are well-informed about the Code. Surveys, resident meetings and direct communication with management provide the opportunity to raise concerns. Advocacy and Code of Rights information is included in the information pack and are available at the service.

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	Staff interviewed could describe the procedures for: maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend church services held within the facility or attend church services in the community if they wish. Residents interviewed reported that they are able to choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education around this has occurred.
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 service has a Māori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. The service can call on The District Health Board Maori liaison service for assistance or advice when required. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff have had training around cultural safety.
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	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Six residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Residents reported that pastoral visits from local church representatives occur.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include: responsibilities of the position, ethics, and advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries. All staff have completed training around professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	The service meets the individualised needs of residents who have been assessed as requiring rest home level care. The quality programme has been designed to monitor contractual and standards compliance as well as the quality of service delivery in the facility. Staffing policies

appropriate standard.		include pre-employment, the requirement to attend orientation and ongoing in-service training. Quality assurance meetings are conducted and staff are invited to attend these meetings. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care, they stated that they feel supported by the registered nurse and management team. Caregivers complete competencies relevant to their practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated their relatives are informed of changes in health status and incidents/accidents. This was confirmed on incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings have occurred three-monthly and the registered nurse and management have an open-door policy. Residents and family are advised in writing of the process and their eligibility to become a subsidised resident should they wish to do so. The service has policies and procedures available around access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. There were no residents requiring this service at the time of audit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Parata Anglican Charitable Trust board provides overarching governance to the service, with support provided by a board trustee/administrator. The manager reports to the administrator, who provides the trust board with a two-monthly report. Two experienced registered nurses provide clinical leadership and oversight. The service provides rest home level care for up to 26 residents. On the day of audit, there were 26 residents. All residents were under the Age-related residential care services agreement (ARCC). Parata rest home has an annual quality plan 2017 – 2018 developed in consultation with the trustees, management and staff. The quality plan includes the aims of the charitable trust, action plan, timeframes and responsibilities. The 2016 quality plan was reviewed in March 2017. The facility is managed by a long-serving manager, who is an enrolled nurse. The assistant manager is the health and safety officer and also an enrolled nurse. A full-time administrator is employed to attend to facility business, human resource management and attend the board meetings. The manager reports to the board. The management team is supported by two part-time registered nurses.

		The manager has completed at least eight hours of professional development in the last year.
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	During the temporary absence of the manager the assistant manager supported by a registered nurse fulfils this role.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The manager facilitates the quality programme and ensures the internal audit schedules are implemented. Corrective action plans are developed, implemented and signed off when service shortfalls are identified. Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. A range of quality improvement data is discussed at monthly combined quality/staff meetings. Meeting minutes reflect discussion of internal audits. Resident meetings have been held regularly. There are policies and procedures provided by an external aged care consultant that are relevant to the service types offered and these are reviewed and updated at least two-yearly or sooner if there is a change in legislation, guidelines or industry best practise. Clinical policies reflect the interRAI requirements. There is a current risk management plan. Hazards are identified, managed and documented on the hazard register. There is a designated health and safety officer. Health and safety issues are discussed at monthly quality assurance/staff meetings with action plans documented to address issues raised. There are resident/relative surveys conducted and analysed. The February 2017 resident/relative survey had been distributed and responses had been collated. Overall residents and relatives expressed 100% satisfaction with the service. Falls prevention strategies are in place for individual residents.
Standard 1.2.4: Adverse Event	FA	The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Seven incidents (all incidents from June

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.		2016 to date) demonstrated appropriate documentation and clinical follow-up. Accidents and incidents are analysed monthly with results discussed at the combined quality assurance/staff meetings. The management team are aware of situations that require statutory reporting. No events have required reporting.
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.	FA	Six staff files sampled (the manager, the registered nurse, the activities coordinator, the cook and two caregivers) show appropriate employment practices and documentation. Current annual practising certificates are kept on file. The orientation package provides information and skills around working with residents with rest home and dementia level care needs and were completed in all staff files sampled. There is an annual training plan in place and implemented. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. Residents stated that staff are knowledgeable and skilled.
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 staffing the service. On the day of audit there were 26 residents. The manager (enrolled nurse) works full-time and along with a registered nurse share after hours on-call cover to support staff. Another registered nurse is available to cover when the registered nurse is on annual leave. The registered nurse works three days per week. The manager also assists with resident care. A senior caregiver is on duty on each shift. Additionally, three caregivers are on duty each morning, two caregivers are on duty on the afternoon shift. At the weekends when the manager is not on duty, an extra caregiver is on duty from 8.00am - 1.00pm and 3.30pm -11.00pm. Staff and residents interviewed confirmed that staffing levels are adequate and that management are visible and able to be contacted at any time. Relatives interviewed reported that call bells are answered promptly and that there are enough staff on duty including when they visit in evenings and at weekends. The roster evidenced an increase in staffing to meet increased occupancy and resident needs.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant staff member including designation. Daily entries in residents' progress notes were evidenced to be written by the manager or registered nurse Monday to Friday. Daily progress notes were evidenced to be written by caregivers at the weekends. More frequent entries were documented when there was a change in resident condition or treatment plan.
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	There are policies and procedures to safely guide service provision and entry to services, including a policy around resident admission. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. Pre-admission information packs including information on the services are provided for resident and families. Admission agreements for long-term residents aligned with contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The yellow envelope transfer system used ensures all relevant documentation is made available to the receiving provider. The residents and their families are involved for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff (RN, ENs, senior caregivers) who administer medications have been assessed for competency on an annual basis. Medications received (blister packs) are checked on delivery by the registered nurse. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored weekly.

		All twelve medication charts reviewed met legislative prescribing requirements, including start and finish times for short term medications, however not all medications being administered were included on all medication charts. The GP has reviewed the medication charts three-monthly. Registered nurse, enrolled nurses and caregivers interviewed could describe their role regarding medicine administration. All staff administering medications have completed an annual medication competency assessment. There was one self-medicating resident at the time of audit and three-monthly competencies had been completed by the RN and GP. The medication round observed was not completed as per policy and procedure. Medication errors were documented on incident forms and investigated with competencies of staff being reviewed where appropriate. The internal auditing programme includes medication audits completed by the registered nurse.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Parata Rest Home are prepared and cooked on-site by a cook who has been employed for many years and a second cook for her days off. A relief cook and kitchenhands provide cover across seven days. All kitchen staff had completed food safety education. There is a four-weekly seasonal menu, which had been reviewed by a dietitian in June 2016. Food preferences are met and staff can access the kitchen at any time to prepare a snack if a resident is hungry. The cook receives a dietary profile of resident dietary requirements and any likes or dislikes including updates. Special diets including modified foods are provided. Fridge, freezer and end cooked temperatures are monitored weekly. Chemicals are stored safely. A cleaning schedule is maintained. Resident meetings along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is a policy that includes declining entry. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission (for new admissions) and six-monthly, or earlier if there is a change in resident health or needs. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/family/whānau. InterRAI assessments, assessment notes and summaries were in place for all residents' files sampled. Long-term care plans in place reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Overall long-term care plans reviewed described the support required to meet the resident's goals and needs, however care needs were not always updated (link to 1.3.6.1). The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process Staff interviewed reported they found the care plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Six resident files were reviewed for this audit. The registered nurse, enrolled nurses and caregivers, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RN will initiate a referral (e.g., to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessments, treatment and evaluations were in place for all current wounds, but not always closed when the wound healed. There was one resident with a non-facility acquired pressure injury (stage two almost healed) and one chronic ulcer. Both wounds have been reviewed in appropriate timeframes. The RN and ENs have access to specialist nursing wound care management advice through the district nursing service and DHB wound care nurse specialist. Interviews with registered nurse, enrolled nurses and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions had not all been updated to reflect when there was a change in residents' needs such as weight loss and the management of pain. Monitoring charts in use included; repositioning charts, restraint monitoring, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight

		management.
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 programme meets the recreational needs of the rest home level care residents and reflects normal patterns of life. The service employs an activity coordinator who works 19.5 hours per week and works Wednesdays, Thursdays and Fridays each week. Activities on a Monday, Tuesday and at the weekend is delivered by volunteers from the community. There is a set activity programme that is resident-focused and is planned around residents' interests and suggestions. There is evidence that the residents have input into review of the wider programme (via resident meetings) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed satisfaction with the programme. The service has a van to transport residents to events in the community and on outings. An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files sampled reflected the specific needs and interests of each resident. Relatives and residents interviewed advised that the activity programme was interesting and the residents were encouraged to participate. In the files reviewed the recreational plans had been reviewed six-monthly at the same time as the care plans were reviewed. Activity participation was noted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by an RN within three weeks of admission. In all files sampled the long-term care plans have been reviewed at least six-monthly. The GP reviews the residents at least three-monthly or earlier if required. Files reviewed demonstrated that short-term needs were documented on short-term care plans, which were regularly evaluated.
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	FA	Referral to other health and disability services was evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The staffing levels policy ensures there is a registered nurse or manager on call at all times and there is at least one person on duty with a current first aid certificate. Except in

provided to meet consumer choice/needs.		emergencies, the registered nurse or manager determines transfer to hospital (often in consultation with the GP). Resident files and interviews confirmed this occurs. The residents and the families are kept informed of the referrals made by the service.
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	All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use as observed during a tour of the home. Material safety datasheets were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Parata Rest Home has a current building warrant of fitness, which expires on 14 June 2018. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. There is a planned schedule to maintain regular and reactive maintenance. Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facilities. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. There is wheelchair access to all communal areas. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans. There is safe access the outdoor areas.
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	All resident rooms have ensuite facilities. There are separate toilets for staff and visitors. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas	FA	All residents' rooms are 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.

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		
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	The communal areas are easily and safely accessible for residents. The outside area is accessible and well maintained. Communal areas within the facility include a large main lounge, a sunroom and dining room for small group and one-on-one activities and quieter seating. There is also a large activities room and a large conservatory/sunroom off the main lounge. Seating and space in the main lounge is arranged to allow both individual and group activities to occur.
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	There are adequate policies and procedures for the safe and efficient use of laundry services. There are dedicated cleaning staff five days a week. Caregivers cover the laundry tasks. All linen and personal clothing is laundered on-site. The laundry is well equipped and well ventilated. Internal audits monitor the effectiveness of the cleaning and laundry processes. The cleaner's trolley is kept in designated locked areas when not in use. There is a sluice room with personal protective equipment readily available.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A civil defence/emergency plan is documented for the service. Civil defence equipment and resources are available and this was discussed with the manager. A gas barbecue is also available. The facility has back-up lighting, power and sufficient food, water and personal supplies to provide for its maximum number of residents in the event of a power outage. The emergency plans and security systems meet regulation requirements. The staff is responsible for checking the facility for security purposes on the afternoon and night shifts. Call bells are accessible in the rooms, lounge and dining areas. There is a staff member on each shift with a current first aid certificate. The New Zealand Fire Service approved the fire evacuation scheme in 1994. Fire drills occur every six months (last fire drill occurred in April 2017). Emergency management training occurs as part of orientation for new staff. Staff interviewed confirmed their understanding of emergency procedures. A call bell system is in place including all resident rooms, ensuites, toilets and communal areas. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. Staff conduct security checks in the evenings to ensure the facility is secure.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a comfortable temperature within bedrooms and communal areas. There are sufficient doors and opening windows for ventilation. All bedrooms have windows, which allow for plenty of natural light.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control person with support from all staff. Infection control matters are routinely discussed at all quality assurance/staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually.
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	There are adequate resources to implement the infection control programme. The registered nurse is responsible for infection prevention and control. The infection control team is all staff through the quality assurance/staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.
Standard 3.4: Education	FA	The staff orientation programme includes infection control education. The infection control

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		person has completed infection control updates and provides staff in-service education. Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting.
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	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality assurance/staff meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. The infection rate is very low and there have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers and restraint is actively minimised. One resident was using restraint (bedsides) and four residents were using an enabler (a bed hoop). Interview with a resident with an enabler and documentation demonstrated that enabler use is voluntary. Training around restraint minimisation and the management of challenging behaviour is documented for 2016 – 17 (last training in June 2017). The service has appropriate documents for the safe assessment, planning, monitoring and review of restraint and enablers. The RN is the restraint coordinator. Staff receive mandatory training around restraint minimisation. All care staff interviewed were able to describe the difference between an enabler and a restraint.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service	FA	The restraint coordinator is the registered nurse. Assessment and approval process for restraint use include the restraint coordinator, resident/or family/whānau representative and medical practitioner. The process includes an assessment, consent and three-monthly review through the quality meeting as well as ongoing individual review.

providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes restraint assessments in partnership/consultation with the resident, their family/whānau and the GP for all residents who are being considered for the use of restraint or enablers. Restraint assessments are based on information in the care plan, resident/family whānau discussions and on observations by the staff. The restraint file reviewed for one resident with restraint contained a restraint assessment which included the factors listed in 2.2.2.1 (a-h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers. Care plans reviewed of a resident with restraint, included specific interventions to manage the identified risks. Monitoring forms were fully completed. Restraint use is reviewed through the monthly restraint register, three-monthly restraint assessment evaluation, quarterly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. Where three-monthly evaluations had been completed, there was evidence that the evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every quarter by the restraint coordinator at quality assurance/staff meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. The restraint coordinator monitors restraint usage. The restraint coordinator reviews relevant Incidents/accidents. Any adverse outcomes are reported at the monthly health and safety meeting and quarterly quality (last review June 2017) meetings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 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	Policies for controlled medications document a safe practice that includes two medication-competent staff signing for medications, one being a registered nurse when a registered nurse is on duty. A review of the controlled drug register evidenced two discrepancies in the balance of one resident’s morphine elixir. This had been identified and discussed with the pharmacy as it was assessed that, when drawing up the controlled medication in a syringe for weekly controlled drug check, the medication had been measured incorrectly. The service has ordered a new glass measuring container as per pharmacist’s recommendations.	On day one of audit a resident was observed to be given controlled medication which was not prescribed on the medication chart. The medication chart had recently been updated by the GP (two days prior to audit). However, the ‘as required’ controlled medication prescribed on the archived medication chart had not been transferred by the GP on to the new medication chart. This was corrected on the day of audit. Two doses of controlled medication had been administered since the medication chart had been rewritten by the GP. An incident form was completed on day one of audit.	(i)Ensure that staff who administer medications follow policy and procedure. (ii)Ensure that a process for reconciliation of medications dispensed against the medication chart is completed when medication charts are updated or there is a change in prescribed treatment. 30 days

		A review of the controlled drug register and medication signing charts evidenced that not all medications had been administered as per medication chart instructions and medication policy and procedure.		
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Four of six care plans reviewed had been updated to reflect when there was a change in residents' needs, one did not address a change in care needs for wound care and one for unintended weight loss. Pain assessments were evidenced completed on admission and were reviewed at six-monthly as part of the care plan evaluation. However, pain assessments were not evidenced to be consistently completed when there was a new episode or breakthrough pain reported.	i) One resident's care plan had not been updated to reflect that a wound had healed, ii) One resident file reviewed identified the resident had significant weight loss, there were no documented interventions to manage the weight loss, iii) Three resident files reviewed did not document that regular pain assessments had been completed. The effectiveness of 'as required' medication administered was not documented by the use of a pain assessment or in resident progress notes.	i-ii) Ensure care plans are updated to reflect the residents' current needs. iii) Ensure that pain assessments and progress notes are completed, which document the administration of 'as required' medication and its effectiveness. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.