

Senior Care Investment Limited - Fraser Manor Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Senior Care Investments Limited

Premises audited: Fraser Manor Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 30 April 2018 End date: 1 May 2018

Proposed changes to current services (if any): Ownership of Fraser Manor Rest Home will change in mid-June 2018.

Total beds occupied across all premises included in the audit on the first day of the audit: 30

Executive summary of the audit

Introduction

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

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

General overview of the audit

Fraser Manor Rest Home provides rest home level care for up to 32 residents. Residents and families spoke positively about the care provided.

Ownership of Fraser Manor Rest Home will change in mid-June 2018. The current and new owners were in attendance during the audit. The newly appointed facility manager is one of the new owners.

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

This audit has identified one area requiring improvement relating to policy management.

Consumer rights

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

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

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

Organisational management

Business and quality and risk management plans prepared by the new owners include the scope, direction, goals, values and mission statement of the organisation. A month long transition to the new owners has commenced. Monitoring of the services provided to the current owner is regular and effective and the new owner indicates they will be continuing this monitoring. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. One restraint is in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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) |
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| Standards | 0 | 49 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 100 | 0 | 1 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and include advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent. Nineteen of 29 residents have an advance directive. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form and this was evident in six of six</p> |

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| | | residents' files reviewed. Where a resident is deemed incompetent to make an informed choice the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were observed to gain consent for day to day care. |
| <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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment for example the attending of a concert once a month at the senior citizens hall and men's day out. The activity co-ordinator interviewed reported that four residents with the support of the community are independent in attending regular community events, such as church and support groups/meetings. There are 13 residents that also attend the 65 plus club in the community which is a club where residents from different facilities gather once a month for the day.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to use the system.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an</p> |

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| | | <p>agreed resolution, are documented and completed within the timeframes. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff. The Code is displayed in the main dining room area, together with information on advocacy services at reception and how to make a complaint and feedback forms.</p> <p>The prospective provider is experienced in health management. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles.</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 and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Five of 30 residents arrange to see their own GP in the community. There are several lounge like areas and small alcoves throughout the facility where residents can meet with their visitors in areas other than their bedrooms. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> |

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| | | Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| <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 | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers acknowledging the four cornerstones of Maori Health which include Whanau (family health), Tinana (physical health), Hinengaro (mental health) and Wairua (spiritual health). Also acknowledged is Whatumanawa (or the emotional health) of the resident. There are two residents who affiliate with their Maori culture and evidence of staff acknowledging and respecting the resident's individual cultural needs was integrated throughout the resident's care planning and activities. Guidance on tikanga best practice is available as required. The families were unable to be interviewed at the time of audit, however evidence of regular communication was sighted in the residents' files. The two residents interviewed reported that they felt supported in their beliefs and very happy with the care provided. |
| <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 | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, such as special foods and choice of activities. The resident satisfaction survey in September 2017 confirmed that individual needs are being met. |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and |

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| | | procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | FA | <p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, wound care specialist, psychogeriatrician, mental health services for older persons, and education of staff. The general practitioner/house doctor (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice noticed were the staff knocking on residents' doors before entering and the observation of staff encouraging and supporting residents to make day to day decisions.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all current residents able to speak English. Staff support a resident who is profoundly deaf and another resident who is profoundly deaf and blind with the use of white boards to support communication along with clear verbal communication and cues. The activities co-ordinator also visits each day and reads the daily mail and news-paper to the resident. The two residents interviewed reported that they were happy with the care that was provided, and despite having a sensory impairment, 'felt part of the home' and included in day to day</p> |

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| | | activities. |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The new owner's strategic and business plan outlines the purpose, values, scope, direction and goals of the organisation. The document describes annual and longer term objectives and the associated operational plans. A sample of reports to the new owners show adequate information to monitor performance is reported including any emerging risks and issues.</p> <p>The service is managed by a facility manager who has relevant experience and has been in the role for one month, she will be continuing in the role for the new owners.. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements.</p> <p>The service holds contracts with the DHB for Rest Home Care (level 2). Thirty residents were receiving services under the contract at the time of audit. At interview the new owner demonstrated knowledge of the ARRC agreement and is seeking an appointment with the DHB contract manager to discuss a current boarder at the Rest home.</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>The recently appointed facility manager will be continuing in her role under the new owners. When the facility manager is absent, a relieving manager will be engaged to carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the senior registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. No immediate staffing changes are planned by the new owner.</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</p> | PA Low | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, regular patient feedback, and clinical incidents including infections. The new owner has</p> |

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| <p>quality improvement principles.</p> | | <p>reviewed the current quality and risk system and will continue implementation of those systems. Over time the quality and risk systems will be incorporated into the new strategic planning.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of data and that related information is reported and discussed at the health and safety and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family feedback is sought quarterly. Most recent results show 95% were satisfied or very satisfied with the service.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies were current. The document control system ensures a systematic and regular review process, approval, distribution and removal of obsolete documents. On review of policies it is noted that some do not make reference to relevant legislation or good practice. The new owner indicates policies will be reviewed over the next six months.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A review of the risk register shows all aspects of the business are included.</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> | <p>FA</p> | <p>Staff document adverse and near miss events on an incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported by the facility manager and the owner.</p> <p>The new facility manager described essential notification reporting requirements, including for pressure injuries. She advised there have been no notifications of significant events made to the Ministry of Health since the previous audit. The new owners have begun involvement in the incident management processes and will continue the current practices into the future.</p> |

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| <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> | <p>FA</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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> | <p>FA</p> | <p>There is a documented good employer policy that states minimum staffing level and skill mix each duty. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to registered nurse advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. There is 24 hour a day, seven day a week on call availability of a general practitioner. The GP undertakes one planned visit per week. The new owner understands the requirements around staff numbers as outlined in the Good Employer policy and intends to retain this policy and the same roster pattern. No immediate staff changes are planned except a job title change for the senior registered nurse to clinical manager.</p> |

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| <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> | <p>FA</p> | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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> | <p>FA</p> | <p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC (Support net) and the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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> | <p>FA</p> | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services including the acute setting, the resident and the family/whānau. The facility will ring the acute setting prior to transfer. At the time of</p> |

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| | | <p>transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed documentation with the use of the 'yellow envelope' and supporting documents. The progress notes sighted showed that the family of the resident was kept well informed during the transfer of their relative.</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> | <p>FA</p> | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. The facility does not have standing orders.</p> <p>There are two residents who were self-administering medications at the time of audit. One of the two residents is identified as a boarder and</p> |

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| | | <p>independent with medications including the organising and delivery of their medications to the facility. The boarder has not had a self-medication competency and her medications were not securely stored. By the end of audit, a secure box was made available. The senior registered nurse interviewed reported that the boarder is fully competent to manage their own medications. The second resident has been assessed six-monthly by the GP and is deemed competent to self-administer medications. Medication in the resident's room was sighted as secure.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>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.</p> | <p>FA</p> | <p>The food service is provided on site by one of two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Tauranga City Council and expires 16 March 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has been employed by the facility for three months and is booked to attend safe food handling training in May 2018, with kitchen assistants/care staff having completed relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> |

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| <p>Standard 1.3.2: Declining 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> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>Information is documented using validated nursing assessment tools such as falls risk, skin integrity, nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents (with the exception of the boarder) have current interRAI assessments completed by one of two trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process. There is currently one resident in the facility with a wound and evidence of a wound management plan was sighted with regular input from the GP. The facility has sent a referral to the wound clinical nurse specialist.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> |

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| <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>FA</p> | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The house doctor (GP) interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |
| <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> | <p>FA</p> | <p>The activities programme is provided by one activity co-ordinator who supports residents Monday – Friday 9 am to 2 pm and supported by a volunteer once a week.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated daily and as part of the formal six-monthly care plan review. The activity co-ordinator each morning will check with staff that no changes have occurred over night and visits each resident to encourage participation in the planned activities for the day or spend one to one with residents who wish to stay in their rooms. If a resident does not attend their normal activities and/or is noted to be spending more time in their room, the activities co-ordinator will notify the clinical nurse manager and document in the progress notes.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive.</p> |

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| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |
| <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> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor/GP', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the wound clinical nurse specialist and mental health services for older people. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> |
| <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> | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. A register of all chemicals held on site was reviewed. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |

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| <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> | <p>FA</p> | <p>A current building warrant of fitness (expiry date 28 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. They included both grassed and paved areas.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>The new owner confirms they have no immediate plans for change of the facility or the campus. Scheduled maintenance will continue..</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> | <p>FA</p> | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 17 toilets and 13 shower rooms for the 30 residents. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</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> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Two bedrooms are licenced for double occupation but are only used for one resident. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> |

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| <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> | <p>FA</p> | <p>Communal areas are available for residents to engage in activities. The dining and three lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |
| <p>Standard 1.4.6: Cleaning And 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>FA</p> | <p>Laundry is undertaken on site in a dedicated laundry. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There are dedicated cleaning staff. The facility was clean and all cleaning equipment and products are stored in a locked room.</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> | <p>FA</p> | <p>Policies and guidelines for emergency planning, preparation and response are documented and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in November 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 30 residents. Water is stored in large containers and there are torches and lanterns in case of power loss. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Each bedroom and communal area has a call bell. Residents and family reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p> |

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| <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>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by underfloor gas in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from a clinical nurse specialist. The infection control programme and manual are reviewed annually.</p> <p>The senior registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the health and safety committee meeting. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>If an outbreak occurs signage is placed at the main entrance to the facility and requests anyone who is or has been unwell in the past 48 hours or 72 hours if history of gastroenteritis, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| <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> | FA | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role eight months. She has undertaken training in infection prevention and control as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and</p> |

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| | | <p>public health unit, Ministry of health and DHB portfolio manager as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when in April 2018 there was a gastroenteritis outbreak and minutes of meetings sighted extra training for all staff including kitchen and laundry staff, residents and families.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p> |

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| <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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, respiratory tract, skin and wound infections (cellulitis, soft tissue, wounds and scabies), gastro-intestinal and eye infections. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Reports identify trends for the current year, and comparisons against previous years and this is reported to the facility manager and staff at meetings. The annual report for 2017 identified that the facility overall had a total of 66 infections, with 2016 showing a total of 62 infections. The report also discusses and breaks down specific infections.</p> <p>For the period of October 2017 – March 2018 the facility recorded a total of six infections, one resident with four infections was identified requiring frequent antibiotics. One resident admitted in December 2017 (not recorded in the monthly surveillance reports) was discharged three of four times back to the facility with antibiotics prescribed and commenced. Both residents have an extensive medical history and co-morbidities. Appropriate interventions in the residents' care plans were sighted to minimise and reduce the risk of infections.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed. From 15 April 2018 to 23 April 2018, 15 residents and eight staff were affected. Documentation sighted demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in</p> |

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| | | <p>the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, one resident was using restraint (bedrails). No residents were using enablers. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p> <p>The new facility manager and owner have been briefed by the senior registered nurse and the general practitioner on practices and requirements when restraint is used. They have access to a copy of the standard and organisation policy.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>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 providers and others.</p> | FA | <p>The restraint approval group, made up of the senior registered nurse and the general practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/EPOA involvement in the decision making was observed in the one case of restraint currently in use. Use of a restraint or an enabler is part of the plan of care.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>Assessments for the use of restraint were documented and included all requirements of the Standard. The registered nurse undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The registered nurse interviewed who is the restraint coordinator described the documented process. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. The file of the resident currently using restraint was</p> |

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| | | reviewed. |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | <p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats and low beds).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and sufficient information provided an auditable record. During 2017 seven episodes of restraint occurred with two occurring in 2018 thus far.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | FA | <p>The file of the resident using restraint was reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. The family confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | FA | <p>Quality review of all restraint use occurs six monthly. Any recommendations for change are documented. No changes were recommended at the last review.</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) |
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| <p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p> | PA Low | <p>Policies are in place to support staff. These cover all aspects of the service and staff say they are easily accessible and useable. Policies are stored in the nurse station or the manager’s office. All policies are current and review dates are noted on each policy. Policies are well written with relevant content, however approx. 40% do not reference legislation or good practice.</p> | <p>Approx 40% of policies do not have evidence of alignment with good practice or reference to relevant legislation.</p> | <p>Policies where relevant should align to good practice and reference relevant legislation</p> <p>180 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.

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End of the report.