

Forrest Hill Continuing Care Limited - Forrest Hill Home and Hospital

Introduction

This report records the results of a Surveillance 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: Forrest Hill Continuing Care Limited

Premises audited: Forrest Hill Home and Hospital

Services audited: Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 4 September 2018 End date: 4 September 2018

Proposed changes to current services (if any): As the service provides care under an Interim District Health Board contract they are required to add hospital and medical (non-acute) care to the services provided.

Total beds occupied across all premises included in the audit on the first day of the audit: 52



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 |
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|  | 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 |
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| Yellow | 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 |
| Red | 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

Forrest Hill Home and Hospital provides rest home and hospital level care for up to 62 residents. The service is privately operated and managed by a general manager with assistance from a clinical manager; both hold current nursing annual practising certificates. The service undertakes interim care for residents who are referred from Waitemata District Health Board (WDHB) for either rest home or hospital level care. The current service streams shown do not cover interim care; however, on the day of audit, as advised by the Ministry of Health senior advisor, hospital and medical services were applied for by the general manager and the audit was extended to cover these requirements and to identify the readiness of the facility to cater for interim care residents. Residents and families spoke positively about the care provided.

This surveillance 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, management, staff, and a general practitioner. The portfolio manager from WDHB supported the service application to have medical and hospital services added to their scope of service.

This audit identified one area of improvement relating to the management of incident and accidents. The service has implemented the required actions for staff competencies related to medication management, addressing the area requiring improvement at the previous audit.

The audit identified that the service meets the requirements to have hospital and medical services added to their provision of care.

Consumer rights

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| <p>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.</p> | | <p>Standards applicable to this service fully attained.</p> |
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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreter services if required.

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

Organisational management

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. Both the general manager and the clinical manager are experienced and suitably qualified persons to oversee all services offered at the facility. Regular reporting occurs between management and the owner/directors.

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 on

specific forms. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff are 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 changing needs of residents.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
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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.

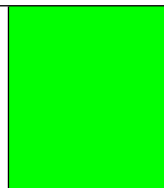
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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.

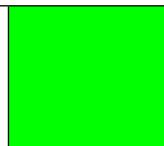
The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and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

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Resident's personal laundry is undertaken onsite with larger items being sent offsite.

Staff are trained in emergency procedures, use of emergency equipment and supplies 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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

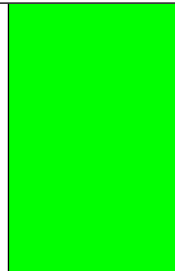


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and one restraint are 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

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.

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

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 | 24 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 58 | 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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <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 do this. Complaints forms are readily available at the facility.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The general 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.</p> <p>There has been one complaint received from the WDHB since the previous audit. This occurred in March 2017 and was closed on 09 October 2017 with all corrective actions being undertaken. As a result of this complaint family are now encouraged to sign off updated care plans to say they agree with the care provision reflected.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p> | <p>FA</p> | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, and 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> |

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| <p>effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>Staff know how to access interpreter services, although reported this was rarely required due to staff being able to provide interpretation as and when needed; the use of family members and communication cards. At the time of audit there was one resident who was not able to speak English. Family interviewed stated that they were very happy with the care provided, staff were able to interpret, and communication cue cards were used. Four residents were identified with a significant sensory impairment. Resources and equipment for their use were sighted for example talking books, regular support from a speech language therapist and the Blind foundation. The facility also provides a three-monthly newsletter to residents and family members. Alternative monthly residents' meetings are advertised and family are invited and encouraged to attend.</p> |
| <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> | <p>FA</p> | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of electronic reports which are accessible to the owner/directors via an electronic shared drive, showed adequate information to monitor performance is reported. Reports include occupancy, financial performance, complaints, maintenance, quality data including emerging risks and issues. The general manager reports at least weekly to one director/owner via email and during telephone discussions.</p> <p>The service is managed by a general manager who holds relevant qualifications and has been in the role for two years. The general manager has held similar positions in other age care facilities over the past nine years. A clinical manager who has been in the role for five years, with 25 years aged care experience, supports the general manager. Both managers are registered nurses with current nursing practising certificates. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements. Both managers confirm their knowledge of the sector, regulatory and reporting requirements and maintain currency through attendance at clinical and management ongoing education held on-site and off-site.</p> <p>The service holds contracts with WDHB for hospital geriatric and rest home level care. Residents were receiving services under the following contracts: -</p> <p>Long Term Support – Chronic Health Conditions – nil residents under this contract at the time of audit</p> <p>Age Related Residential Care – 36 hospital level care and 15 rest home level care (two of which are under the primary options for acute care (POAC).</p> <p>Additionally Interim Care Scheme – one hospital level care resident was receiving services under this contract at the time of audit. The general manager applied for a reconfiguration of services provided to include medical hospital in the scope. Discussions with the portfolio manager and the general manager showed that neither person was aware that the current identified service streams covered interim care contractual requirements.</p> |

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| <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> | <p>FA</p> | <p>When the general manager is absent, the clinical manager and organisational quality manager carry out all the required duties under delegated authority. During absences of clinical manager, the general manager and a senior registered nurse oversee all clinical management and are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of adverse events, complaints, audit activities, a regular patient satisfaction survey, outcome oversight, clinical incidents including infections, falls, wounds and pressure injuries.</p> <p>Meeting minutes and quality data documentation reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, registered nurses meetings, and quality and staff meetings. The owner/directors have direct electronic access to all data via a shared drive. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions and ongoing projects. Relevant corrective actions are developed and implemented to address any shortfalls. (Review of incident and accident corrective actions are not well documented. Refer comment in criterion 1.2.4.3) Resident and family satisfaction surveys are completed annually. The most recent survey completed in October 2017 showed that the majority of residents and family members were either satisfied or very satisfied with services. Follow up actions were taken in response to the negative responses received and included the GP responding to feedback at a meeting with the people concerned. Concerns raised related to the maintenance for the outside areas of the facility and resulting corrective actions were shown. No negative comments were received from the residents or families at the time of audit.</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 are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has</p> |

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| | | implemented requirements. All risks are reviewed by the health and safety committee. |
| <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> | PA Low | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed incidents were investigated; action plans developed and corrective actions were implemented in a timely manner. Very few of the forms reviewed identified the outcomes of the corrective actions. The incident and accident forms are kept in a separate file and not placed with the resident information at any time. During discussion with the clinical manager it was agreed that incident and accident forms would be filed in the resident clinical file from this time on.</p> <p>Adverse event data is collated, analysed and reported to management, and at all staff meetings. This information is then placed onto a shared drive which is accessed by the owner/directors. The general manager also includes the incident accident numbers in a weekly email to the owner/directors.</p> <p>The general manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have no police investigations, coroner's inquests; issues based audits and any other notifications since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <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. The service has updated their orientation package to better reflect the roles undertaken by staff. One domestic staff member's orientation documentation was limited but identified that they had covered the very basics of emergency management, fire, and policy reading. All other files contained completed orientation booklets.</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 after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Education is undertaken to an appropriate level and reflects care provision standards required to manage residents who enter under the interim care contract. The service has sought and sent staff and management on specific courses and education related to in-depth medical care management of residents such as management of patients with intravenous antibiotics (OPIVA) and recognising signs of change in palliative residents by use of current best</p> |

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| | | <p>practice palliative care pathways. The OPIVA training has been specifically designed to assist registered nurses working in private hospitals within aged care to manage residents with central venous lines who require an extended length of intravenous antibiotic therapy in the comfort of their own facility. The GP confirmed care is delivered to a high standard.</p> <p>Staff training records identified all education undertaken and staff interviewed confirmed that on-site education is undertaken at least twice a month with input from the gerontology nurse specialist, hospice nurses and other guest speakers. Staff stated that if they request a topic of interest this is added into the education programme.</p> <p>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 for interRAI.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. This is confirmed on the rosters sighted and during staff interviews. An afterhours on call roster is in place, with staff reporting that good access to 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 and there is 24 hour/seven days a week (24/7) RN coverage. As there is no increase in bed numbers for the reconfiguration of services to include hospital and medical care, the staffing numbers are adequate to meet the requirements.</p> <p>The general manager works across two sites, both owned and operated by the same provider. Part of each day is spent at Forrest Hill Home and Hospital and she is always contactable via telephone. The diversional therapists cover seven days per week for seven hours per day. The activities coordinator works eight hours per day, five days a week. Dedicated cleaning staff work 13 hours Monday to Friday and seven and a half hours in the weekend. Laundry staff work seven and a half hours, seven days a week. Kitchen staff cover is available from 6am to 2pm and then 3pm to 7pm. Seven days a week. The maintenance person works across the two sites Monday to Friday and the maintenance book identifies all requested maintenance is completed promptly.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p> | FA | <p>The medication management policy is current and identifies all aspects of medicine management in line with legislative requirements and the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a paper-based 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 are competent to perform the function they</p> |

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| <p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>manage. The previous audit identified an area for improvement to ensure that all staff who hold medication responsibilities are competent to perform the function they are assigned. The corrective action is now addressed, and records were available to demonstrate that health care assistants supporting as the checker of controlled and other medications including on a night shift is medication competent.</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. The service has registered staff and the support of community specialists to manage medical residents. Clinical pharmacist input is provided once a month.</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 was consistently recorded on the medicine chart.</p> <p>There are no residents who self-administer medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food service is provided on site by one of two cooks, supported by kitchen staff, 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. A new menu is due to be commenced and this has also been reviewed by a qualified dietitian in August 2018.</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 ministry of primary industries and expires June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification.</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. The total numbers of beds would not change with the addition of medical residents. The cook interviewed stated that they can manage all menus and different foods/diets required for all residents.</p> |

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| | | Evidence of resident satisfaction with meals was verified by resident and family interviews and in residents' 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. Families interviewed stated that the 'cook is fantastic', covering a wide range of cultural dishes, food preferences, regularly visits residents and has discussions with family to ensure that they are happy with the food, providing alternative options if needed. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents 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. The 'house doctor' interviewed, verified that medical input is sought in a timely manner that medical orders are followed, and care 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 including the admission and ongoing support of medical residents. |
| 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 activities programme is provided by a lifestyle coordinator who is a trained diversional therapist in Australia and has recently commenced level four papers in New Zealand, a project administrator, activity coordinator and a chaplain. The activities staff support residents from Monday to Friday 7.30am to 3.30pm and Saturday and Sunday from 9.00am to 3.00pm. 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 three monthly and as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents are supported by the staff and groups in the community to partake in regular community activities and groups. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun. |
| Standard 1.3.8: Evaluation Consumers' service | FA | Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or |

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| <p>delivery plans are evaluated in a comprehensive and timely manner.</p> | | <p>as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of working documents throughout the ten residents' files reviewed. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds and falls. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |
| <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 06 July 2019) 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. There is adequate equipment available, including electric beds, three lifting hoists and three weigh scales (sit on and stand on). Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. The equipment is suitable for hospital and medical level care.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. One negative comment was made in the resident satisfaction survey related to the umbrellas not being available for the outdoor tables in winter. This was fully addressed as identified in documentation sighted and the umbrellas were in place at the time of audit.</p> <p>Staff confirmed any requests for maintenance are appropriately actioned and that they are happy with the</p> |

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| | | environment. |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes shared toilet and shower ensuites between two rooms across 24 bedrooms, and 34 bedrooms that have individual ensuites. There are three bedrooms without a shower or toilet which are located close to the central shared bathroom areas.</p> <p>All bathroom areas are of a size which allows lifting equipment to be used if required which makes them suitable for hospital and medical care. 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> | FA | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There is one bedroom which two beds can be placed in, however, the general manager stated that this is used as a single room and would only be used as a double room if requested by residents. All other bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>The door width and room size is adequate for hospital and medical care as equipment can easily be moved around safely.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are</p> | FA | <p>Communal areas are available for residents to engage in activities. The dining and 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. The areas are suitable for hospital and medical care residents.</p> |

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| <p>provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining 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>Resident's personal laundry is undertaken on site in a dedicated laundry. Other items of laundry are sent off site and washed by a contracted provider. Dedicated laundry 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. Staff confirm there is always adequate clean linen available. As there would be no increase in bed numbers the system currently used for laundry is suitable for hospital and medical care.</p> <p>There is a small designated cleaning team who have received appropriate training. As confirmed in interview of cleaning staff and training records staff have completed safe chemical handling education/training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</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 displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe 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 on the 11 September 2014. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 15 May 2018. 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 62 residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis by the clinical manager. The response time to call bells is monitored by the clinical manager to ensure call bells are responded to promptly by staff.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff undertake regular nightly checks.</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 and opening external windows. Heating is provided by electric wall heaters in residents' rooms with communal areas being centrally heated. The heaters in resident bedrooms are being upgraded as part of the ongoing maintenance programme. 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 the clinical manager. The infection control programme and manual are reviewed annually. The programme is suitable for hospital and non-acute medical residents.</p> <p>The clinical manager/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 senior management and the owner/director which are tabled as part of the staff meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, 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 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/clinical manager reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</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. Trends are identified from the past year and these are reported by the clinical manager to all staff. Fifty</p> |

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| <p>and methods that have been specified in the infection control programme.</p> | | <p>residents and 30 staff in April 2018 consented to the flu vaccine.</p> <p>The facility has had a total of 24 infections since February 2018 with no infections identified in May 2018. One resident has been identified with three of those 24 infections due to co-morbidities. The residents' file reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is not currently benchmarked.</p> <p>The IPC coordinator/clinical manager interviewed stated that there have been no infection outbreaks in the last 12 months.</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 the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Annual restraint education is undertaken on-site for staff and this was last presented on 17 April 2018.</p> <p>On the day of audit, one resident was using restraint and six residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. All enablers and the restraint are bedside rails.</p> <p>The clinical files were reviewed specifically for one resident with restraint and one resident with an enabler. This confirmed consent is obtained, three monthly reviews are up to date, information is identified on interRAI assessments and it is shown on the care plans. The restraint register is up to date.</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> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|---|-------------------|--|--|---|
| <p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p> | PA Low | <p>The service documents all adverse events on specific incident and accident forms. This information is used as an opportunity to improve service delivery and manage risk. Corrective actions taken are documented but outcome reviews are not always documented. Staff confirmed during interview that corrective actions required are implemented and reported at daily handover meetings held each shift. The service keeps incident and accident forms in a separate folder and the information is not merged into the resident information at any time.</p> | <p>Incident and accident forms are not kept with the resident clinical file and outcomes of corrective action reviews are not always documented.</p> | <p>Provide evidence that resident information is integrated into resident files and that the results of the corrective actions implemented are documented.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.