T M & D L Beer Holdings Limited - Cardrona Rest Home & 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	TM & DL Beer Holdings Limited
Premises audited:	Cardrona Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 May 2019 End date: 28 May 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 31

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Cardrona Rest Home and Hospital is a family owned business. The service and a sister facility are led by a general manager. The service provides care for up to 35 residents across rest home and hospital levels of care and on the day of audit there were 31 residents.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The general manager was employed in February 2015. The general manager is responsible for all non-clinical related activities for two aged care facilities with the same ownership. She is supported by a clinical operations manager/registered nurse who works at this site and another site owned by the same owners in another town.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

This audit did not identify any areas requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. The service has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

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.

There is a current building warrant of fitness. The environment is safe and appropriate for the levels of care, and a maintenance programme is implemented.

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 service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There was one resident using restraints and four with enablers at the time of the audit.

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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	18	0	0	0	0	0
Criteria	0	44	0	0	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. There have been no complaints since 2018. Residents (three rest home and three hospital – including one person funded under a younger person disabled contract) and family members, advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes. A health and disability complaint was recorded for November 2018. The Health and Disability commissioner has closed the complaint pending a series of follow up actions due to the commissioner during July 2019. All actions are implemented as per the Health and Disability service letter including; monthly care plan audits, all care plan changes have a signing sheet to ensure all staff are aware of changes, three monthly care plan reviews (these include phone calls to relatives), staff training and mobility cards in resident rooms. All issues identified in the Ministry of Health letter dated February 2019 as a follow-up to the Health and Disability complaint, have been evidenced to be fully compliant. Specifically; falls and manual handling training (1.2.7), timeframes content of initial care plans (1.3.3), the assessment process (1.3.4), care plan documentation (1.3.5) and implementation of care plan interventions (1.3.6).

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The general manager and clinical operations manager confirmed family are kept informed. Relatives interviewed (two hospital), stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys, three monthly resident reviews and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Cardrona Rest Home and Hospital is a family owned business. The service and a sister facility are led by a general manager. The service provides care for up to 35 residents across rest home and hospital levels of care and on the day of audit there were 31 residents. There were twenty rest home residents - including one funded through the long-term chronic health care contract. There were eleven hospital residents - including two residents admitted under the young person with disability contract. Services are provided over two levels connected by a small internal ramp. The lower wing has fifteen beds including one double room and the upper wing has twenty beds including five double rooms. There are 12 dual-purpose beds. An annual business plan has been developed that includes a philosophy, values and measurable goals. The service organisation philosophy reflects a person/family-centred approach. Business goals have been reviewed and summarised and the 2019 business plan has been documented and is being implemented. The general manager was employed in February 2015. The general manager is responsible for all non-clinical related activities for two aged care facilities with the same ownership. The general manager is on site at Cardrona Rest Home at least three days per week. She is supported by a clinical operations manager/registered nurse who works at this site and another site owned by the same owners in another town. The clinical operations manager/registered nurse has been at this facility for approximately nine years. The clinical operations manager/registered nurse is on site at Cardrona Rest Home two days per week. Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented,	FA	Cardrona Rest Home and Hospital has a well-established and comprehensive quality and risk programme. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (five caregivers, two registered nurses, the cook and the activities

and maintained quality and risk management system that reflects continuous quality improvement principles.		person) confirmed they are made aware of any new/reviewed policies. The general manager (part owner) and clinical operations manager (RN) work closely together. The general manager ensures that directors are made aware of any issues arising. Monthly staff minutes sighted, evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Staff meetings also evidenced discussion and training for identified issues such as pressure injuries, manual handling, falls prevention and specific resident needs. The staff interviewed were aware of quality data results, trends and corrective actions. There is a robust internal audit programme that covers all aspects of the service and includes action plans where needed, with sign off once resolved. Quality improvement plans were documented for; improving the appraisal process for staff, a staff champion for pressure area care and an in-depth action plan following a Health and Disability complaint, which has been approved by the complainant family. All action plans document follow-up and ongoing evaluation. There is an implemented health and safety and risk management system in place including policies to guide practice. The general manager and clinical operations manager are responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings. Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service collects incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the monthly staff meetings. Seven incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The clinical operations manager collects incident forms, investigates and reviews and implements corrective actions as required. The managers interviewed could describe situations that would require reporting to relevant authorities. The service has not reported any issues, with the DHB and Ministry of health aware of the ongoing HDC complaint.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs, and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. Staff interviewed believed new staff are adequately orientated to the service on employment. There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session, records of training reflect good attendance. Falls training and manual handling training was provided to staff September 2018, and meeting minutes reviewed for 2019 also document that falls are discussed each month, including fall minimisation. Three of the seven RNs have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager have access to external training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a policy that determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager and clinical operations manager manage across two facilities. There is a registered nurse rostered for all shifts seven days a week. Caregivers are rostered as follows for 20 residents at rest home and 11 at hospital level; for the AM and for the PM shifts there are two long shifts and one short shift, and two caregivers overnight. There are separate kitchen, laundry and housekeeping staff. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical and facility manager who respond quickly to after-hour calls.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders on a computerised system with photo identification and allergy status documented. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and caregivers with medication administration responsibilities. Administration records sampled were

guidelines.		appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. There were no residents who self-administered medicines. Standing orders in place where up-to-date and complied with the Standing Orders Guidelines 2016.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Cardrona are prepared and cooked on site. There is a food services manual in place to guide staff. The food service menu was last audited by a dietitian in December 2016 and the food control plan verified August 2018. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. The cook is aware of any residents with weight loss and provides non-prescribed high protein supplements as instructed by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met. The cook meets with residents during meal times, and observes and receives verbal feedback on the menu. The cook has strong links with the RN team where she monitors resident's meal consumption, records food wastage and reports to the RN about those residents of concern. Meals are plated and served from the kitchen to the rest home and hospital residents in the dining room. A tray service is available for those residents who wish to have their meals in their rooms. Staff were observed assisting residents with their meals and drinks. Fridge and freezer temperatures are checked daily with evidence of corrective actions taken as needed (recordings sighted). End cooked food temperatures are recorded daily. Dry goods are stored adequately. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed their food safety course. There are specialised crockery, plates, mugs and utensils to promote resident independence with meals. Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food service provided.
Standard 1.3.4: Assessment Consumers' needs, support	FA	Initial interRAI assessments and reviews are evident in printed format in all resident files including the younger person disabled resident and the resident funded through the long-term chronic health care contract. Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound care,

requirements, and preferences are gathered and recorded in a timely manner.		falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans are resident-focused and personalised. The care plans describe the resident goals, supports and interventions required to meet desired goals, as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview that they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Interventions appropriate to the younger resident were documented in the younger person file and the resident funder through the long-term chronic conditions contract (who was also under 65). Integration of records and monitoring documents are well managed. Short-term care plans are in use for changes in health status and are evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist and physiotherapist. The care staff advise that the care plans are easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans sampled were goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary. There were ten residents with thirteen wounds at the time of the audit. This included two stage one and two stage two facility acquired pressure injuries and one stage one, one stage two and one unstageable (all non-facility acquired). The long-term care plans reviewed were resident-focused and personalised. The care plans describe the resident goals, supports and interventions required to meet desired goals, as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview that they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as needed. The GP was very complimentary regarding the service and nursing leadership. Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed. Residents and family members interviewed confirmed their satisfaction with care delivery.

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	There are three activity staff employed who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for five days per week with activities provided by caregivers over the weekend. Each resident has an individual activities assessment on admission, which is incorporated into the interRAI assessment process. An individual activities plan is developed for each resident by the activities staff in consultation with the resident, families and RNs. The activity programme is driven by resident choice and planned monthly. Each resident is free to choose whether they wish to participate in the group activities programme or their own planned personal programme. Participation is monitored and documented. Young people with disabilities are able to participate in a range of activities to support their interests, hobbies and life-long goals. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. One-on-one time is spent with residents who choose not to participate or are unable to join in the activity programme. Van trips are provided, and the resident interviewed said they enjoyed them. All resident files sampled have a recent activity plan within the care plan and this is appraised at least six-monthly when the care plan is evaluated or when there is a significant change. Residents and relatives interviewed are satisfied with the current activity programme and the one-on-one companionship provided to the residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurse interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	FA	The building has a current building warrant of fitness which expires in December 2019. A reactive and planned maintenance programme is implemented. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained.

accessible physical environment and facilities that are fit for their purpose.		Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment (including personal equipment to support individual needs) to safely deliver the cares as outlined in the resident care plans for all people receiving services.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. One resident was admitted on the day of audit with bedrail restraints and four with enablers at the time of the audit. Care plans reflected the use of restraint or enabler and all appropriate assessments, consents and reviews were in place as needed.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.