

# CSR Healthcare Limited - Heritage Remuera Rest Home

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## 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:

<b>Legal entity:</b>	CSR Healthcare Limited
<b>Premises audited:</b>	Remuera Rest Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 29 May 2019    End date: 30 May 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	33

# Executive summary of the audit

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## 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
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

Remuera Rest Home and Hospital provides rest home and hospital (geriatric) levels of care for up to 35 residents. On the day of the audit there were 33 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 facility manager has significant experience in health management and has been in the role for six years. The facility manager is supported by two clinical leaders (registered nurses).

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

The two previous shortfalls identified as part of the previous audit have been addressed. These were around water temperatures and management of resident's who smoke.

This audit identified a shortfall around staff rostering on night shift.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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.		Some standards applicable to this service partially attained and of low risk.
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There is a business plan with goals for the service that has been regularly reviewed. Remuera rest home and hospital 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.
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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 recreations officer. 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 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.
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There is a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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 were five residents using restraints and no residents 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.
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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)
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	0	40	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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 three verbal complaints made in 2019 year to date. All three complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant. Five residents (including one younger person) interviewed advised that they are aware of the complaint's procedure and that the manager always addressed any concerns very quickly. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The facility manager and clinical leaders confirmed family are kept informed, with five care plans all documenting family communication sheets. Residents/relatives have the opportunity to feedback on service delivery through annual surveys 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. There were no family available for interview during the audit.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident</p>



conducive to effective communication.		should they wish to do so. There is access to an interpreter service as required.
<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>Remuera rest home and hospital provides rest home and hospital (geriatric) levels of care for up to 35 residents. Fifteen rooms are designated for rest home level of care and twenty rooms are designated as dual-purpose (hospital/rest home). On the day of the audit there were 33 residents (20 rest home and 13 hospital). This included two residents on the young persons with disabilities (YPD) contract (hospital level). All other residents were funded through the ARRC agreement with the DHB.</p> <p>The service has a business plan and quality and a quality and risk plan. The business plan identifies the purpose, values and scope of the business plan. The plan documents an annual review. The service has quality goals, which has a review timetable. The plan documents regular reviews as per the timetable. The facility manager has significant experience in health management and has been in the role for six years. The manager provides regular reports to the owner as well as emails, and weekly meetings. The manager has been given a broad scope to manage the service as well as budgetary control. The manager is supported by two clinical leaders (registered nurses), with a background in aged care.</p> <p>The manager has completed at least eight hours of professional development.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Remuera rest home and hospital has a well-established and comprehensive quality and risk programme.</p> <p>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 (four healthcare assistants, two RN clinical leaders, one chef, and one reactions officer) confirmed they are made aware of any new/reviewed policies.</p> <p>Monthly quality meeting 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. Monthly comparisons include detailed trend analysis and graphs.</p> <p>Facility meetings held include quality and health and safety, full staff meetings, kitchen meetings, resident and relative meetings, diversional therapy and cleaners' meetings. Meetings minutes sighted, evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. Meeting minutes evidenced that quality data is used as a training tool to improve services.</p> <p>There is an implemented internal audit programme that covers all aspects of the service. Outcomes from internal audit outcomes are provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p>

		<p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is 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.</p> <p>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.</p> <p>Annual surveys have been undertaken. The 2019 survey documents a significant improvement from 2018 with overall rating moving from 85% satisfied to 95%. The 2019 survey has a documented action plan for any area that scored lower than expected and included; activities (a new person has been employed), meals (more vegetables have now been included in the menu) and staff approachability/attitude (meetings document that this has been discussed regularly).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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.</p> <p>Ten 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 healthcare assistants interviewed could discuss the incident reporting process. The facility manager collects incident forms, investigates and reviews and implements corrective actions as required. One incident involved a resident with behaviours that challenge. This resident was re-assessed and transferred to a different level of care. Resident smoking indoors is a reporting KPI for the service and monthly reports reviewed identified that there have been no issues for the month of May reviewed. Previous months documented smoking issues for one resident, all of which had been followed up. This resident's care plan included safe smoking interventions.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. No reporting has been required to the MoH or DHB since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>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 RN clinical leaders and three healthcare assistants). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. 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.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>There is an implemented annual education planner in place that covers compulsory education requirements as well as ad hoc training as part of monthly staff meetings. The planner and individual attendance records are updated after each session. Two of the six RNs have completed interRAI training. Clinical staff complete competencies relevant to their role.</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>PA Low</p>	<p>The human resources policy 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.</p> <p>There are two clinical leaders/RNs appointed who hold additional RN responsibilities. There is a minimum of one RN/clinical leader on duty 24/7. Two RNs are rostered during the day, one day a week to cover GP rounds plus additional days such as admission days and interRAI assessments. Staffing is flexible to meet the acuity and needs of the residents.</p> <p>Overall there are adequate numbers of healthcare assistants available with staff extending their hours where needed. Two healthcare assistants are rostered on the AM shift, seven days a week and the PM shift includes one 15:00 hr to 23:00, one 15:00 to 21:00 and one 16:00 to 20:00. There is one healthcare assistant on nights.</p> <p>However, night shift does not meet the requirements of ARC D17.4a.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RNs and facility manager, who respond quickly to after-hours calls. Two RNs and four healthcare assistants interviewed stated that the service is very supportive and there is a family atmosphere.</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 paper-based 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 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 (i.e. eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and healthcare assistants with medication administration responsibilities. Administration sheets sampled were 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. No residents self-administer medicines and the service does not use standing orders.</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>There is a well-equipped kitchen and all food is cooked on-site with two main cooks over seven days a week. There is a food service manual in place to guide staff. There is a four-weekly seasonal menu (last reviewed by a dietitian 22 May 2017). A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Special diets are catered for, along with those of different cultures. Mealtimes observed evidenced attractive, well presented meals with staff available to assist residents with meals as needed.</p> <p>The chef and facility manager interviewed stated they continue to review resident feedback and alternatives are offered. The puree meals are presented attractively.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans sampled were goal orientated and reflective of the interRAI and other assessments. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Daily stop and watch meetings ensure that the RNs are informed of any changes to resident condition and healthcare assistants are updated on specific care interventions.</p> <p>There were seven wounds logged onto the wound log at the time of the audit. One resident had a grade two pressure injury and one grade four. Assessments, management plans and documented reviews were in place for all wounds.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as needed. A GP visits at least two weekly and as needed. The GP expressed that the staff provide a very good service and RNs have a good skill set.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p> <p>Residents interviewed confirmed their satisfaction with care delivery.</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</p>	<p>FA</p>	<p>There is one recreation officer employed who is a qualified social worker, who is responsible for the planning and delivery of the individual and group activities programme with assistance from staff and volunteers. There are organised activities for five days a week.</p> <p>Group activities are provided in the communal lounge/dining room. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>activities programme is developed monthly, and a weekly programme posted up on the wall in the lounge. The group programme includes residents being involved within the community with social clubs, churches and schools. Community links such as van trips to art galleries, trips to cafés for coffee and individual activities are available for all residents, including younger residents.</p> <p>The recreation officer interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop an individual plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate, is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>The service has its own van for transportation. Van drivers for residents have a current first aid certificate. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<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>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Each resident has a written evaluation of care six monthly and care plans updated. There was documented evidence that care plan evaluations were current in resident files sampled. 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. 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.</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>The building has a current building warrant of fitness (expires 25 June 2019). Maintenance is coordinated by the manager who employs contractors for both the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored, and has remained below 45 degrees, this is an improvement from the previous audit. The facility has sufficient space for residents to mobilise using mobility aids. Residents have adequate internal spaces to meet their needs. External areas are accessible, and shade is available. There is a designated smoking area. The service has included the monitoring of residents who smoke as a specific KPI and the resident who exhibits risky smoking behaviour such as smoking inside has this in their care plan. This is an improvement from the previous audit.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Equipment such as oxygen, catheterisation sets, syringes and syringe drivers and pressure relieving devices are on site to meet the needs of hospital level residents.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 were five residents using restraints and none with enablers at the time of the audit. Two resident files for residents with restraint documented that assessments, consents and care plans for the restraint had been documented along with three monthly reviews.</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 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>There is a minimum of one RN/clinical leader on duty 24/7. Two RNs are rostered during the day, one day a week to cover GP rounds plus additional days such as admission days and interRAI assessments. Two healthcare assistants are rostered on the AM shift, seven days a week and the PM shift includes one 15:00 hr to 23:00, one 15:00 to 21:00 and one 16:00 to 20:00. There is one healthcare assistant on nights.</p>	<p>Staffing at night does not meet the intent of the ARC contract D 17.4a</p>	<p>Review the staffing on night to meet the requirements of the ARC contract.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.