

J & R Manuel Limited - Phoenix House Resthome and Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	J & R Manuel Limited
Premises audited:	Phoenix House Resthome and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 July 2021 End date: 8 July 2021
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:	28

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

Phoenix House Rest Home and Hospital is privately owned and operated and cares for up to 30 residents requiring hospital and rest home level care. On the day of the audit, there were 28 residents.

The service is managed by a facility manager who has been in the role since November 2016 with support from the previous owner, and registered nurses. Residents and family and the GP interviewed, spoke very highly about the service provided. The service remains a whānau centred and owned business providing a home like experience for the community of Coromandel.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management, and an interview with the general practitioner.

There are well-developed systems, processes, policies, and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the quality and risk management programme. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

Two shortfalls were identified during the audit to documentation of corrective action plans when issues were identified, and to completion of medication competencies.

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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Policies are documented to support resident rights and residents state that their rights are upheld. Individual care plans include reference to residents' values and beliefs. Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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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The facility manager has support from the previous owner (registered nurse) whenever this is required. The facility manager is also the clinical manager.

There is a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards. Quality data is discussed at facility meetings.

Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of care. An orientation and training programme is documented. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for the administration of medicines, with senior caregivers acting as checkers/second signatories for controlled medications. The medication charts (paper-based) are reviewed three monthly by the general practitioner.

The recreational therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

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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The building holds a current warrant of fitness. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are policies and procedures on safe restraint use and enablers. The facility manager (registered nurse) is identified as the restraint coordinator. There is no restraint used by residents. There were three residents using a bedrail or lap belt as an enabler during the audit. Staff receive training around restraint and behaviours that challenge.

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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the service. There is a dedicated Covid folder including a pandemic plan and guidelines. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated, and reported to relevant personnel 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	43	0	1	1	0	0
Criteria	0	91	0	1	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with the facility manager, two RNs, the clinical services lead (registered nurse), four caregivers, cook, recreational therapist, lead administrator/caregiver and cleaner confirmed their familiarity with the Code.</p> <p>Training around the rights as described in the Code includes advocacy, informed consent, privacy, and identification of any abuse is provided at least annually with all staff having had this training in the past year.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in six resident files (four hospital, and two rest home) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p>

		Six resident files sampled have signed admission agreements.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. An advocacy poster is displayed in a visible location in both Māori and English. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Education is provided by the local HDC advocacy service.</p> <p>Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p> <p>Interviews with the residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Examples include van outings, and church services, attendance at local art exhibitions and local theatre, and Matariki celebrations. Local entertainers visit the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families/whānau during entry to the service. Access to complaints forms are located at reception. A complaints register is in place. There are no complaints since the last audit. The facility manager and staff stated that they respond to any concerns or ideas immediately so that they do not escalate into complaints.</p> <p>Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. They advised that they had no complaints or concerns about the service and found the staff and managers very approachable.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The facility manager discusses aspects of the Code with residents and their family/whānau on admission. The Code is</p>

<p>Consumers are informed of their rights.</p>		<p>displayed in English and Māori throughout the facility. All residents interviewed (six rest home and four hospital), and four family/whānau interviewed with a family member at rest home level reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>There is a policy that describes spiritual care. There is access for residents to spiritual support whenever this is required. All residents interviewed indicated that their spiritual needs are being met as this is required.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.</p> <p>The facility manager identifies as Māori (Ngati Maru, Ngati Whanaunga, and Ngati Pukenga ki Manaia) and Pakeha and in their words, this is a symbol of Te Tiriti o Waitangi. They identify three marae that they connect with: Mania Narae, Harataunga Marae and Te Paea Marae.</p> <p>Over 60% of staff at Phoenix House identify as Māori and have strong links with the local iwi (Ngati Maru, Ngati Whanaunga, Ngati Tamatera and Ngati Pukenga) and Hauraki Māori Trust Board. Staff regularly speak te reo Māori with the Māori residents. Local kaumātua are available to support residents and the facility when required (e.g., to bless rooms, to support residents requiring palliative care, to visit family members etc).</p> <p>Cultural values and beliefs that are identified through the assessment process are documented in the resident's care plan. Forty percent of residents living at the facility identify as Māori. The Māori residents interviewed confirmed that their cultural values and beliefs were met, and tikanga principles are imbedded in the care practices in use.</p> <p>Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family/whānau and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline.</p> <p>Beliefs and values are discussed and incorporated into the residents' care plans, as evidenced in all care plans reviewed (two rest home and four hospital). Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The registered nurses supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation and staff receive training around how to identify abuse or neglect and the process for reporting. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. The service continues to perform cyclical renovations of all rooms and communal areas. Heat pumps have been replaced and extra eco-friendly heating panels have been added where needed.</p> <p>The resident and family satisfaction survey was sent out in 2020 and completed survey forms returned demonstrated high levels of satisfaction with the services provided. The resident meeting includes feedback on any issues that are concerning residents and ideas of how to improve the service. There was evidence that the residents' feedback (as appropriate) is acted upon. Residents interviewed spoke very positively about the care and support provided and stated the management team are very approachable. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. A van is on site for regular outings.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families/whānau have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Family/whānau document the circumstances and timeframes they wish to be contacted, regarding the notification of a change in health condition or an adverse event. The 15 accident/incident forms reviewed reflected documented evidence of families/whānau being informed following an adverse event. Families/whānau interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. A family/whānau communication sheet is held in the front of the residents' files.</p> <p>An interpreter service is available and accessible if required, through the DHB. Families/whānau and staff are utilised in the first instance.</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>Phoenix House is a family owned and operated facility that was established in 1987. The original owners sold the business to members of the family in 2009. The facility manager receives support from the previous owner (clinical services lead) who was on site supporting the team on the days of audit. Both the owner/director and the clinical services lead are registered nurses with current annual practicing certificates.</p> <p>The facility manager is a registered nurse (RN) with 30 years of nursing experience in the community and hospital setting. They have a Bachelor of Nursing and Diploma in Business and Administration.</p> <p>The facility provides care for up to 30 residents at rest home and hospital level of care. There were 28 residents on the day of audit. There were 18 rest home residents and 10 at hospital level (including one under a post-acute care [PAC] agreement, one under a long-term service – chronic health care [LTS-CHC], and one funded by ACC for respite care). All other residents were under the Age-Related Care Contract.</p> <p>An annual business plan has been developed that includes a philosophy, values, and measurable goals. Business goals have been documented for 2021 with the previous 2020 business plan reviewed prior to the 2021 being developed.</p> <p>The facility manager has completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the absence of the facility manager, the previous owner (clinical services lead) who is also a registered nurse with a current APC assumes responsibilities. They are aware of their responsibilities as described when interviewed.</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>	PA Low	<p>A quality and risk management programme is in place. Interviews with the facility manager and staff reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.</p> <p>Quality data collected is collated and analysed. An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan in some cases, with corrective actions being signed off at staff meetings to evidence their implementation. Quality data is regularly communicated to staff via monthly staff meetings, and a copy of the previous meeting minutes are kept in the staff room. Meeting minutes reviewed for 2021 showed that discussions occur and when documented, actions are resolved in a timely manner.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (lead administrator/caregiver) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review at the end of 2020).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	FA	<p>An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all 15 accident/incident forms selected for review.</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The manager is aware of the requirement to notify relevant authorities in relation to essential notifications. There have not been any section 31 reports required to be sent to the Ministry of Health to notify them of any serious incidents since the last 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>	<p>FA</p>	<p>There are human resource management policies in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience, and veracity, evidenced in six staff files randomly selected for review (lead administrator/caregiver, two registered nurses, two caregivers, and cook).</p> <p>Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all six staff files. Annual staff appraisals were up-to-date.</p> <p>An in-service education programme is being implemented. Competencies for staff are also completed (link 1.3.12.3). Regular in-services are provided by a range of in-house and external speakers including (but not limited to) nurse specialists, Aged Concern and the Health and Disability Advocacy Service. The service also has access to an aged care on-line learning programme. Caregivers are encouraged and supported to complete Careerforce with six caregivers having completed level two, two completed level three, and three who have completed level four training. There are four caregivers currently enrolled in level four training.</p> <p>There are two registered nurses who are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Phoenix House policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents.</p> <p>There is a registered nurse rostered on each shift for 28 residents.</p> <p>On a morning shift there are five caregivers - three long, and two short shifts. On an afternoon shift, there are three caregivers - two long and one short shift. There is also a caregiver on between 5 pm and 7 pm to help with dinner and supervision of the lounge. On a night shift, there is one caregiver. Extra staff can be called on for increased resident requirements and this was confirmed by staff interviewed. There are no bureau staff in the area and casual staff and part time staff do extra shifts</p>

		<p>when required.</p> <p>Activities staff are rostered on five days a week. A morning caregiver completes the laundry, and reported there is adequate time allocated for this.</p> <p>Interviews with staff, residents and family/whānau members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed, and signed by the carer, and include their designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The owner/manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The six admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the manager or a registered nurse are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</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>PA Moderate</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit, however policy and procedures outlining assessment, review and safe storage are in place should the service require it. There are no standing orders, and no vaccines are stored on site.</p> <p>The facility uses a paper-based medication management and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications and senior caregivers act as checkers/second signatories for controlled medications, however, there was no evidence of up-to-date medication competencies. There has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily. Eye drops viewed in the medication trolley had been dated once opened.</p> <p>Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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 lead cook oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring January 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian.</p>

		All residents/families interviewed are very complimentary about the meals provided. Additional snacks are available at all times.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed excluding one YPD resident. Initial interRAI assessments and reviews were evident for four of six resident files sampled (excluding YPD and ACC respite).</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, wound care specialist and speech and language therapist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included three chronic wounds, one post-surgical, and two cancerous lesions.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. All monitoring requirements including neurological observations had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are three recreational therapists who plan and lead all activities, covering Monday to Friday, with resources being available for care staff, residents and families to use at the weekends. Residents were observed participating in planned activities during the time of audit, including group exercise in the main lounge, with the recreational therapist adapting exercises to the various abilities of the clients to facilitate a fun and inclusive session.</p> <p>There is a weekly programme in large print on noticeboards, with residents being advised of activities verbally on a one-to-one basis by staff also. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, floor games and bingo. The residents enjoy happy hour daily.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are at least weekly outings to local areas of interest including beaches utilising a wheelchair accessible minibus. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Matariki are celebrated. There are visiting community groups such as various church denominations and a local ukulele group.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Four of six resident care plans reviewed (excluding the resident on respite and YPD resident in</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>service less than 6 months) had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Care plan evaluations were documented and reviewed progress to meeting goals. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurses interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</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>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</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 holds a current building warrant of fitness expiring 3 June 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, the hoist and scales are checked annually and are next due to be checked June 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained. All external areas have attractive features, including extensive grounds which are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All resident rooms share communal showers and toilets. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs and a hoist if appropriate. There are privacy signs on all shower/toilet doors.
<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	There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. One lounge opens out onto an attractive courtyard/garden area. There are dining rooms in each wing. The dining areas are homely, inviting and appropriate for the needs of the residents.
<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>	FA	All laundry is done on site. There is a defined clean and dirty flow within the laundry area. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.

<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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas barbeque is available. The service has their own generator which is checked monthly.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.</p> <p>There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p>
<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>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</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>	<p>FA</p>	<p>Phoenix House Rest Home and Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The facility manager (registered nurse) is the designated infection control coordinator with support from all staff as members of the infection control team.</p> <p>Infection control is discussed at the staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually (last reviewed December 2020).</p> <p>Visitors are asked not to visit if they are unwell. Residents and relatives interviewed stated they were kept well informed on visiting restrictions during the lockdown period. Covid screening for visitors and contractors continue. Influenza vaccines are offered to residents and staff. Alcohol gel is freely</p>

		available throughout the facility.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The facility manager is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>The service has a supply of personal protective equipment which is checked weekly. A DHB representative completed a site visit to assess the facility preparedness in the event of a pandemic. The DHB and Phoenix House Rest Home and Hospital provided sufficient supplies of personal protective equipment. PPE is checked monthly by the facility manager to ensure that supplies are sufficient.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are Phoenix House Rest Home and Hospital infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. There is a dedicated Covid folder including DHB and MOH guidelines. Reviewed/new policies are discussed at staff meetings.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed education in infection control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in resident records.</p> <p>Staff have been trained in use of PPE relevant to Covid-19. They have also been provided with</p>

		education around Covid, hand hygiene, extra cleaning and other relevant topics related to Covid-19 and pandemic management. A record of training is kept for each staff member.
<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 surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. .</p> <p>There have been no outbreaks since the previous audit. The facility manager had identified an area that could be used to isolate any residents should they become infected with Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. The policy states that the facility prefers no or minimal restraint. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents using restraint. There were three residents using enablers for safety. These were a lap belt for one resident and bedrails for the others. The three residents using enablers had given consent voluntarily. Staff receive training annually around challenging behaviours and restraint.</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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	There is a process to document any corrective actions when these are identified through audits, increases in rates of falls or when issues are identified. Corrective action plans were not always well documented when issued were identified (e.g., an increase from 14 falls in January 2021 to 22 falls in February 2021)	Corrective action plans are not always well documented when issues arise or when data shows an increase past the clinical indicator (e.g., for falls)	<p>Ensure that corrective action plans are documented when issues arise or when there is data that shows an increase related to a clinical indicators.</p> <p>180 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Moderate	There are policies and procedures to ensure medication competency, however current competencies could not be evidenced.	There is no documented evidence of annual medication competencies for registered nurses or caregivers administering/checking	Evidence those responsible for medication management are competent to perform the function for each stage they manage.

			medications.	60 days
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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.

No data to display

End of the report.