

Clair House Limited - Claire House Aged Care Facility

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: Clair House Limited

Premises audited: Claire House Aged Care Facility

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 5 August 2021 End date: 6 August 2021

Proposed changes to current services (if any): This audit included verifying the addition of two rest home service bedrooms that has increased the total certified bed numbers from 55 to 57.

Total beds occupied across all premises included in the audit on the first day of the audit: 53

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

Claire House Aged Care provides rest home level care for up to 55 residents. On the day of the audit there were 53 residents.

This certification audit was conducted against the relevant 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, relatives, management, staff, and the general practitioner. Two further resident bedrooms were verified as part of this audit. The total number of beds after verification is 57 beds.

The residents, relatives and general practitioner spoke highly of the care and service provided at Claire House. The service has a well-established quality system that identifies ongoing quality improvement.

This audit identified shortfalls related to wound assessments and medication management.

Consumer rights

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

The staff at Claire House ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaint's policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

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

An experienced owner/manager has owned and managed the facility for more than 30 years. They are supported by an assistant manager, quality coordinator and two registered nurses. There is a 2021 business plan in place. Regular audits take place as scheduled in the annual quality plan. There is a risk management programme, which includes incident and accident reporting and health and safety processes.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is ongoing training provided as per the annual developed training plan. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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>
---	--	---

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, develops care plans, and reviews each resident's needs, outcomes, and goals at least six monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

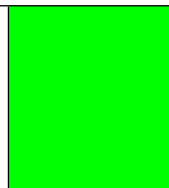
Medication policies are documented. Registered nurses and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three monthly.

An activity coordinator implements the activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes and special dietary requirement are met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the three villas. The three buildings (villas) each hold a current warrant of fitness.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Resident bedrooms are spacious and personalised. Some resident rooms have ensuites. There are adequate communal shower/toilet facilities.

Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

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.

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. Two residents were using enablers and no residents were using restraints at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Responsibility for infection control is shared between the two registered nurses. The infection control coordinators have attended external education and coordinate education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks since the last audit.

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>Two managers were interviewed during the audit. They were the owner/manager and assistant manager. Interviews with the health services manager, two registered nurses (RN), seven healthcare assistants (HCA), one cleaner, one cook, a health and safety representative, personal assistant, and one activity coordinator confirmed their familiarity with the Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code)). Staff apply this knowledge to their daily practice. All staff receive training about the Code during their induction to the service and annually as part of the training programme. The recent annual training around the Code took place in January 2021.</p> <p>Fourteen residents and two relatives interviewed stated they receive services that met the Code.</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their enduring power of attorney (EPOA). The admission agreements have been signed on admission in the sample of files reviewed. Advance directives sighted in the resident files were signed appropriately. The HCAs and managers confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in</p>

give informed consent.		decisions that affect their relative's lives.
<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	Information on advocacy services is included in the resident information pack and is provided to new residents and their family on arrival. Advocacy brochures and contact numbers are available at the main entrance area. Staff receive annual education and training on the role of advocacy services. The recent advocacy training was completed for all staff in January 2021.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.</p> <p>The service encourages the residents to maintain their relationships with their 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 as observed during the audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. Information about the complaints policy and procedure is provided on admission and the complaints folder is displayed in each resident's room. The owner/manager and the RNs operate an 'open door' policy. Residents and relatives confirmed they are aware of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register held electronically. One complaint has been received from the Health and Disability Commissioner (HDC) in 2019. The complaint has been resolved and closed. Five complaints were received in 2020, and seven complaints were lodged in 2021 year to date. There was documented evidence of each complaint being acknowledged, investigated and resolved in a timely manner.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Information of the Code and advocacy services are available at the main entrance of Claire House. This is explained to the residents and their families or power of attorney (EPOA) on entry to the service by the operator/owner, clinical manager, assistant manager, or registered nurse. Each resident's room is provided with a hard copy of the Code, a copy of the complaints process, and advocacy information. Residents and relatives stated they received adequate information on

		resident rights.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed could describe correctly what 'privacy' means to them and the residents. House rules are signed by staff at commencement of employment. HCAs interviewed reported that they always knock on doors prior to entering the rooms, as observed during the audit. Resident's independence is encouraged at all times. There is a policy on abuse and neglect. Incidents were reviewed for 2021 and there were no incidents around abuse. Staff and the general practitioner interviewed confirmed that there was no evidence of abuse or neglect. Staff receive annual training around abuse and neglect, with this held last in 2020. Information around the residents spirituality, culture, values and beliefs is discussed on admission to the service, and are included in care planning.</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>	FA	<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 staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident, and were able to explain how to meet the cultural needs of residents identifying as Māori. There are no residents living at the facility who identify as Māori. All residents were assessed for cultural needs as part of the interRAI assessment and care planning process.</p> <p>There is a policy for recognition of Māori values and beliefs. There is a Māori health plan in place. The service can also access support through the Māori Health Unit at the district health board if required. There are two staff members employed who identify as Māori.</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>	FA	<p>Cultural, spiritual beliefs, and individualised resident values are discussed on admission to the service, and incorporated in the residents' care plan. This is achieved in collaboration with the resident, family, and/or their representative. Advisors are available when required. Staff interviewed confirmed that they are committed to ensuring each resident has individual needs met as sighted in the review of eight resident files reviewed. Residents and families interviewed confirmed they are involved in developing the resident plan of care, which includes their identification of individual values and beliefs. Staff receive annual culture competence training, with this last provided in 2020.</p> <p>There are spiritual services, and residents are encouraged to attend their own spiritual care in the community if they can. There is at least one church service a week, that any resident or family</p>

		member can attend.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. A code of conduct is part of the new employee's induction to the service and is signed by the new employee. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents. Professional boundaries are defined in job descriptions.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment, or financial exploitation. Professional boundaries are reconfirmed through education and training sessions, and managers stated that performance management would address any concerns if there was discrimination noted.</p> <p>Healthcare assistants interviewed confirmed their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Claire House has well established systems and processes. All policies and procedures have been developed in line with current best practice and are reviewed regularly with the support of an external consultant. The 2021 business plan outlines a number of priorities such as transfer of all paper-based staff appraisals to an online version and looking into options for future dementia/hospital units.</p> <p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety.</p> <p>Staff interviewed feel that they are well supported by the management with their professional development. Claire House has an annual calendar which has monthly training and audit activities. This programme demonstrates the commitment for continuous quality improvement and staff professional development. The annual staff satisfaction survey was completed in August 2020. Staff interviewed during the audit reflected their satisfaction with the service. They spoke of working as a team to improve the lives of residents.</p> <p>Residents interviewed spoke very positively about the care and support provided. Both family and residents interviewed stated that the managers were very visible and encouraged open discussion at all times. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. HCAs complete competencies and training relevant</p>

		to their practice.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and their families receive explanation about the services and procedures on the entry. Interpreter services are made available to those residents who have difficulties with verbal or written English. Families interviewed stated they were kept well informed on their resident's health status. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The information pack is available in large print and can be read to residents who are visually impaired.</p> <p>Residents and family interviewed stated that they were kept well informed about Covid-19 and changes in practice as they related to levels announced by the Ministry of Health.</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>	FA	<p>Claire House currently offers rest home level care for up to 55 residents. On the day of audit there were 53 rest home residents in total, including 38 residents under the Age-Related Care Contract (ARCC), eight residents under a private contract, two residents under the Young Persons with a Disability (YPD) contract, and three under the Long-Term Support - Chronic health Conditions (LTS-CHC) contract and two residents under a mental health contract.</p> <p>Claire House has three named units and a villa; Claire House has 18 beds with 16 residents including the residents on LTS-CHC, and mental health contract. Clairemont has 16 beds of 16 residents, Fleurmont has 16 beds of 16 residents and Claire Villa has five beds of five residents.</p> <p>This audit also included verifying two additional resident rooms in Claire House as suitable for provision of rest home level care. The total number of beds is now at 57.</p> <p>There is a 2021 business plan with goals, timeframes, and responsibilities. The quality programme annual calendar sets the whole year's quality activities. The quality improvement register is maintained and discussed at the monthly staff/quality meeting. Goals include (but are not limited to); improving the 'Family Care plan Input Review Form' from paper based version to an online version and 'review the HCAs task form'.</p> <p>The owner/manager is non-clinical and has owned and managed the facility for more than 30 years. The owner/manager is supported by an assistant manager who has completed a Bachelor's in business management. The managers are also supported by a quality coordinator and two registered nurses. The owner/manager lives in an adjoining property and is available 24 hours a</p>

		<p>day/seven days a week if necessary.</p> <p>The management team have completed more than the required eight hours education in relation to managing an age care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The owner/manager confirmed that in the event of their absence, the assistant manager along with the registered nurses providing clinical support would take over management of the service. Support would also be provided from the quality coordinator.</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>Claire House has an established quality and risk management system. There are policies and procedures in place to ensure the service is meeting accepted good practice and adhering to relevant standards. The 'quality annual calendar' schedules monthly activities.</p> <p>There are monthly combined quality and staff meetings. Staff sign their attendances electronically. Minutes sighted between January and July 2021 confirmed the evidence of discussion of quality data, review of incidents and accidents, infection control, operational issues, and concerns/complaints. An internal audit schedule is implemented with corrective actions resolved in a timely manner (link 1.3.12.6). The audit may be repeated to ensure that actions have been taken to address issues. An annual satisfaction survey is taken with residents and family stating that they were very satisfied with services provided in 2020.</p> <p>The monthly health and safety meeting has a regular agenda. The meeting minutes confirmed that the corrective actions were taken with evidence that there is resolution of issues. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. There is a health and safety check monthly. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of orientation. There is a current hazard register (last reviewed in August 2020) in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward</p>	FA	<p>Incident and accident data is collected and analysed monthly, and a report documented for the monthly quality/staff meeting. Thirteen incident/accident files (seven unwitnessed falls, two skin tears, two medication errors and two other medication issues) were reviewed. Family members</p>

<p>events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>were notified accordingly. Incident reports evidence appropriate clinical follow up. Neurological observations have been completed following all unwitnessed falls with potential for head injury. Opportunities to minimise future risks (where able) were identified.</p> <p>The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The management team were able to describe statutory reporting requirements. Since the last audit, there has been one report to an external authority for a coroners investigation. There have not been any other notifications required to any other external authority.</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 resources policies to support recruitment practices. Seven staff files (three HCAs, two registered nurses (RN), one activities coordinator and one cleaner) were reviewed and all had relevant documentation relating to employment. Staff appraisals are completed annually. Annual practicing certificates were maintained for qualified staff and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service. Care staff complete competencies as part of orientation relevant to their roles.</p> <p>There is an annual education plan that is outlined on the annual calendar. The 2021 education plan is being implemented. A competency programme is in place with different requirements according to work type (eg, HCAs and RNs). Core competencies are completed, and a record of completion is maintained. Staff interviewed were aware of the requirement to complete competency training and commented that the current education programme was informative and interesting.</p> <p>Staff are encouraged and supported to complete Careerforce training. Currently there are six HCAs at level 0, three HCAs who have completed level 2, four with level 3, and 14 with a level 4 certificate. All staff have current first aid certificates.</p> <p>There are two registered nurses, who are both interRAI trained. The registered nurses have access to external education, and have completed external infection control training. Both registered nurses have gained post graduate certificates in the last year.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increase in staffing depending on the acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>covered, and a review of rosters confirmed that staff are replaced when on leave.</p> <p>Interviews with staff confirmed that they feel that staffing levels are sufficient to meet the needs of residents. The owner/manager and assistant manager both work 40 hours per week from Monday to Friday and two RNs are working between 8-5 and 10-6 respectively. The owner/manager is available on call for afterhours.</p> <p>Claire House currently has 18 beds with 16 residents on the day, including the resident on the LTS-CHC and two residents under the mental health contract. Claremont has 16 beds with 16 residents on the day. These two units are in the same building and staffed as one. The morning shift has four HCAs rostered on morning shift from 7am to 3pm. There are two HCAs rostered from 3pm to 11pm. Two HCAs are rostered from 11 to 8am.</p> <p>Fleurmont has 16 beds with 16 residents on the day. Two HCAs cover the morning shift, and one HCA is rostered on the afternoon and nightshifts.</p> <p>Claire Villa has five beds with five independent residents on the day. One HCA is rostered in the morning. The manager/ owner is on call for the villa in the afternoon and night.</p> <p>There are designated staff for activities, food services and laundry/housekeeping. The staffing will remain the same with the addition of the two 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>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff could describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident files are protected from unauthorised access.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Admission agreements reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	<p>FA</p>	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit,</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.</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 policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior HCAs who administer medications complete annual medication competencies with these sighted on file. Annual in-service education on medication administration and management is provided by the supplying pharmacist. Medications are checked on delivery against the medication chart and any discrepancies feedback to the pharmacy. All medications are stored safely in the villas. Standing orders are not used and there are no vaccines on site. There were no residents self-administering medications during the audit although there was a self-medication competency available to complete if a resident was to self-administer medication. The kitchen fridge is used as the medication fridge with the temperature monitored daily. Medication stored in the fridge was in a locked box.</p> <p>Short course medication that had a short expiry date after opening (eg, eye drops) were not always dated when opened. There were no corrective actions documented when an issue was identified around documentation in the controlled drug register. One old medication box was found in the fridge; however, this was disposed of on the day of audit with staff reminded to check the back of the fridge during the audit.</p> <p>Sixteen pharmacy generated medication charts were reviewed along with six medication cupboards (three in Claire House, two in Fleurmont and one in the five bed villa). All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The dose and time given is signed for on the administration signing sheet. Pain monitoring forms record the effectiveness of pain relief.</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>All meals and home baking is prepared and cooked on site by qualified cooks. There is a four-weekly seasonal menu in place which had been reviewed by a dietitian in October 2019. The chef is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals are provided. Six monthly residents' food satisfaction survey are completed. There have been changes to the menu and increased resident satisfaction with meals as a result of survey feedback. Residents and family members interviewed were very complimentary about the meals provided.</p> <p>The main kitchen is adjacent to the dining room in Claire house where all meals are prepared.</p>

		<p>Meals are plated and delivered in hot boxes to the dining rooms in Fleurmont villa and the five-bed villa situated on the site. Fridge and freezer temperatures (in all villas) are monitored and recorded daily. End cooked temperatures are taken twice daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained.</p> <p>The Food Control Plan will expire in April 2022 with the service having attained an 18-month certificate.</p> <p>Residents interviewed were very happy with food provided.</p>
<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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The RNs complete an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes for long term residents under the ARCC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. The long-term care plans reflect the outcome of the assessments.</p> <p>There were two wounds, however wound assessments did not clarify the state of each.</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>Residents' long-term care plans reviewed were resident-focused and individualised. Care plans documented the required supports/needs to reflect the resident's current health status. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed three monthly and updated to reflect changes to supports/needs.</p> <p>Short-term care plans were sighted for short term needs and these were either resolved or transferred to the long-term care plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident.</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>When a resident's condition changes, the RN initiates a review and if required, and/or GP consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments were briefly documented (link 1.3.4.2). A wound care plan (includes dressing type and evaluations on change of dressings) was in place for two chronic wounds. There is access to a wound nurse specialist and district nurses for advice for wound management if required.</p> <p>Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours. Monitoring forms are completed as required including completion of neurological observations if a resident has an unwitnessed fall or hits their head.</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>An activity coordinator is employed five days a week for a total of 28 hours with two more flexible hours if required. Their role is to coordinate and implement an activity programme that meets the recreational needs of the resident groups. Volunteers and nursing students are involved in implementing aspects of the programme.</p> <p>Activities are very individually based with residents encouraged to access the community as much as possible. A daily programme is offered each day from Monday to Friday. Activities are meaningful and include exercises to music, crafts, group walks, bowls, quizzes, board games, painting, and art. Entertainment occurs in the weekends. There are visiting churches, library, grammar school students and pet therapy. All festivities and birthdays are celebrated. Van rides are offered every four weeks. Residents are supported to attend their own church and other community functions.</p> <p>Younger persons are supported to maintain their community links and are also involved in meaningful activities such as assisting with the activities or tasks within the villas and grounds. Personal planning/assistance is allocated within the activities programme for all residents and also focusing on the needs of younger people in regard to shopping, individualised activities, and interests.</p>

		A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six monthly. The service receives feedback on activities through one-on-one feedback, resident's meetings which are held monthly, and surveys. Residents interviewed confirmed that they are very satisfied with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six monthly for seven of the eight resident files reviewed. One resident had not been at the service six months. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets and products charts are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely in laundry areas of the main villas (Claire House, Clairemont and Fleurmont villa) and in a locked cupboard in the five-bedroom villa. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The three separate care villas (Claire House/ Clairemont, Fleurmont villa and the five bed villa) all have a current building warrant of fitness that expires 30 September 2021. There is a maintenance person employed for seven hours per week and on-call for urgent facility matters. A reactive and planned maintenance schedule is in place.

<p>for their purpose.</p>		<p>There has been ongoing refurbishment of rooms including new carpets and ongoing enhancement of gardens and outdoor area. Annual calibration, functional checks and electrical testing and tagging of equipment is completed by external contractors annually.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade is provided. The facility has a designated resident smoking area away from the buildings.</p> <p>The HCAs interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury resources, and a hoist (for use in the case of falls) to safely deliver the cares as outlined in the residents' care plans.</p> <p>The audit verified two new bedrooms in Claire House. They were not occupied on the days of audit but were ready for occupancy. The rooms were previously utilised as a separate laundry which is no longer required, and a staff office.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The majority of resident's rooms in the villas have ensuites while some have shared ensuites. There are communal toilets and showers for those in rooms without ensuites. Communal shower/toilets have privacy locks. Residents confirmed staff respect their privacy while attending to their hygiene cares. The occupants of the two new bedrooms have individual ensuites.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single. Each resident room has individual furnishings and décor. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. The two new bedrooms are ready for occupancy. Both are fully decorated, and appropriate equipment has been put in place including a bed and chest of drawers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p>	<p>FA</p>	<p>Communal areas within the facility include a dining area and lounge for each area Claire House, Clairemont upstairs and downstairs, Fleurmont upstairs and downstairs and the five bed villa). Activities take place in the lounges of Claire House and Fleurmont. All furniture is safe and suitable</p>

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		<p>for the residents. Communal areas are easily accessible to residents. There is a lift to each of the upstairs rooms in Claire House and Fleurmont.</p> <p>The occupants of the two new bedrooms will use existing dining, lounge, and outdoor areas for activities. There is enough furniture in the communal areas to accommodate two more residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on site. Healthcare assistants' complete laundry duties. There is a designated laundry with a defined clean/dirty area in the upstairs of Clairemont and Fleurmont villas. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings, and surveys. There are dedicated cleaners Monday to Saturday to carry out cleaning duties in the villas. Cleaning trolleys are stored safely when not in use. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency management plans are in place to ensure health, civil defence and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly. The last fire evacuation drill occurred on in June 2021. Civil defence supplies are available and checked at regular intervals. There is alternative gas heating and cooking including BBQs and gas cookers. Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency. There are sufficient emergency supplies of stored water available on site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. There is an emergency management manual in place. External providers conduct system checks on alarms, sprinklers, and extinguishers.</p> <p>First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light up outside each room and on two display panels in the nurse's station.</p> <p>Pendant call bells will be provided to new occupants in the two new bedrooms. These are linked to the existing system and are operational.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Forty rooms have doors that open out onto

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>individual deck/balcony. All bedrooms have adequate natural light. Both new bedrooms have large villa size windows.</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>Claire House 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. An experienced registered nurse is the designated infection control nurse with support from the second registered nurse. The infection control nurse has a job description. Minutes of the monthly continuous quality improvement meeting which includes infection control are available for staff.</p> <p>Influenza vaccines are offered to residents and staff annually. Residents and staff have received Covid vaccines. Visitors and family are advised not to visit if they are unwell. Covid screening on entry to the service has continued. There are adequate hand sanitisers available. The infection control programme has been reviewed annually last in March 2021. Visitors are asked not to visit if unwell.</p> <p>There have been no outbreaks since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has attended infection control and prevention education provided by an external provider. There is access to infection control expertise within the DHB, wound nurse specialist, public health, laboratory, GPs, and external infection control consultant. The GP monitors the use of antibiotics.</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</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a consultant. There is sufficient personal protective equipment available with each villa having their own supply.</p>

procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<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 coordinators are responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete hand hygiene competencies. There has been additional education provided around Covid alert levels, restrictions and donning and doffing of personal protective equipment.</p> <p>Resident education is expected to occur as part of providing daily cares with documentation of this in resident records.</p> <p>Visitors are advised of any outbreaks of infection and are advised not to visit until the outbreak has been resolved. Information was provided regularly to residents and visitors regarding Covid alert levels and visiting restrictions by phone or email.</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>Systems in place are appropriate to the size and complexity of the facility. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review, and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections is entered onto a monthly infection summary.</p> <p>The infection control officer provides infection control data, trends, and relevant information to the continuous quality improvement meetings. Areas for improvement are identified, corrective actions developed and followed up. If there is an emergent issue, it is acted upon in a timely manner.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is consistent with the definitions in NZS 8134.0. Interviews with the staff confirmed their understanding of restraint minimisation.</p> <p>At the time of the audit there were two residents with enablers (grip pole), and no residents with restraint in the service. There was a documented consent for each of the enablers signed by the resident. Staff training has been provided around restraint minimisation and management of challenging behaviours annually, with the most recent training completed in May 2021.</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 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>The RNs had identified an issue related to documentation in the controlled drug register. This included crossing out balances, overwriting or scribbling over balances and replacing the documentation in four entries identified, and writing ‘approximate’ for one balance (elixir). The RNs stated that staff had been provided with training at the time. The audit identified the same issues that had occurred after the last training (inaccurate documentation noted in July and August 2021).</p> <p>Medications with a short expiry time (eg, eye drops) were not always dated when opened. Two of the five medications with a short expiry date were dated, however the other three were not.</p>	<p>i) Information in the controlled drug register is crossed out, scribbled over, or overwritten at times in the controlled drug register.</p> <p>ii) The date of opening medication which has a short expiry date (eg, eye drops) was not completed on three of five medications in</p>	<p>i) Ensure that any errors made in the controlled register are managed as per policy with an incident form documented and a corrective action plan put in place if the issues continues.</p> <p>ii) Date medication which has a short expiry date (eg, eye drops) when opened.</p> <p>60 days</p>

			use.	
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	There were two chronic wounds. Both wounds were identified in the care plan, however a full assessment of each was not completed and staff could not state what the depth, width, if there was any exudate, etc for each. Some general notes were made.	A full assessment of two wounds were not recorded prior to the wound management plan being developed.	<p>Ensure that a comprehensive assessment of the wound is completed when the wound is identified.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.