

Well Health Care Limited

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Well Health Care Limited
Premises audited:	Fencible Manor Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 December 2014 End date: 16 December 2014
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:	16

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.

General overview of the audit

Fencible Manor Rest Home provides rest home level of care for up to eighteen residents. On the day of the audit there were sixteen beds occupied. This provisional audit included interviews with the present owner and prospective purchasers.

There were areas identified for improvement relating to document control, medicine management, consent and human resources.

Consumer rights

Care provided to residents at Fencible Manor Rest Home is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected. Residents and family/whanau members interviewed report that care received is respectful of their rights and privacy and they feel safe and are not harassed or discriminated against.

There is a system in place to manage complaints which meets legislative requirements.

Consent forms for services were sighted in residents' files reviewed. An improvement is required related to staff knowledge about the validity of advance directives.

Fencible Manor Rest Home informs residents and their family/whanau of how to access the Nationwide Health and Disability Advocacy Service and encourages residents to maintain connections with family/whanau, friends and community support groups and services.

The proposed new owners verbalised their knowledge and understanding of residents' rights.

Organisational management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The organisation's governance systems for clinical care, staffing, operational and financial aspects of the service are monitored monthly and reported to staff.

The service is managed by an appropriately experienced and qualified registered nurse who is responsible for the overall running of the service. There is an additional registered nurse who provides clinical support to the staff. The nurse manager reports to the current owner of the service directly.

The service has an established and documented quality and risk management systems. Quality outcomes data are analysed to improve service delivery. A comprehensive internal auditing programme is in place, which links to the clinical governance monitoring and reporting system for the early identification of potential areas that could be improved. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There are sufficient policies and procedures which describe all aspects of service delivery and organisational management; however, these are not all up to date nor are the documents well controlled. This requires an improvement.

The human resources management system provides for the appropriate employment of staff and on-going training processes. An improvement is required to ensure that all staff have a current job description. The education programme is available for all staff and education records document staff attendance.

There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery to the residents. Rosters sighted document an appropriate number of skilled and experienced staff being allocated each shift and this meets the requirements of the provider's contract with the district health board and standards for safe staffing in residential care.

The prospective owners reported on interview that they will be supported by the present owner and understand the risk management plan requirements as one of the prospective owners is the Nurse Manager currently. A sale and purchase agreement which specifies ongoing support is currently being formulated. The existing owner reported that she will be available for assistance with the new owners for as long as required. The quality and risk management systems, policies and procedures will be retained. The nurse manager is familiar with all the systems that are currently used and this will assist with her prospective new role as owner-manager.

Continuum of service delivery

Information packs provided to anyone making an enquiry, contained information on entry criteria, service inclusions/exclusions and residents' rights. The organisation keeps the Needs Assessment Co-ordination Service (NASC) informed of the service level provided, which is rest home level care only.

There was evidence that residents' needs are assessed on admission by nursing staff and the GP. All residents' files sighted provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis with the resident, and where appropriate their family/whanau. Resident and family/whanau members interviewed reported the care provided at Fencible Manor Rest Home is of a high standard.

Planned activities were enjoyed by residents and the activities provided reflect their likes, interests and level of ability.

Medicine management policies and procedures are not always implemented by staff and this is an area requiring improvement.

The menu has been reviewed as meeting nutritional guidelines by a registered dietitian. Residents' special dietary requirements and cultural needs were met. Interviews with residents verified a high level of satisfaction with meals.

The prospective owners demonstrated understanding of the requirements to maintain a safe continuum of service delivery.

Safe and appropriate environment

The building warrant of fitness expires in April 2015. The environment is maintained to a standard that meets legislative requirements. The previous areas for improvement have been addressed. The prospective owners stated they have no plans to change the environment.

Restraint minimisation and safe practice

There were no enablers or restraints in use at the rest home at the time of audit. The rest home was designed to allow maximum freedom of movement while promoting the safety of residents. The service maintains processes for determining approval of all types of restraint, should restraint be required.

Infection prevention and control

The infection prevention control programme enables the provider to control the environment safely. Reporting lines are clearly defined, with the infection control co-ordinator reporting directly to the facility manager who reports to the owner.

There is a clearly defined infection prevention and control programme for which external advice and support was sought. An infection control coordinator, who is a registered nurse, is responsible for this programme, including education and reporting surveillance data.

Infection control policies and procedures are reviewed annually. Infection prevention and control education is included in the staff orientation programme, annual core training and on topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and results are reported through all levels of the organisation, including governance.

One of the prospective owners works at Fencible Manor Rest Home as the registered nurse and is the current infection control coordinator.

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	39	0	3	0	1	0
Criteria	0	84	0	3	0	2	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>Services provided by Fencible Manor Rest Home (Fencible Manor) complied with consumer rights legislation as confirmed in policy documents and interviews with four staff, five residents and four family/whānau members. Staff education was covered during orientation and on an ongoing basis as part of in-service education programme. Clinical staff were observed to address residents by their preferred name, explain procedures, seek verbal acknowledgement for a procedure.</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>	PA Low	<p>Admission documentation informed the resident and their enduring power of attorney (EPOA) of inclusions and exclusions in service. During discussion with the prospective owners they confirmed their understanding of what residents were entitled to and what additional services can be charged for.</p> <p>Signed consent related to long term care treatment which met the requirements of these standards were sighted in all four residents' files reviewed. Residents were able to select their GP of choice. Verbal</p>

		<p>informed consent was observed to be gained by staff on the day of audit. Staff interviewed verbalised that they understood the informed consent process related to a resident's rights to decline services at any time.</p> <p>Residents' choices and decisions for advance directives, such as resuscitation, were recorded in the four residents' files reviewed. An issue raised in the previous audit has been addressed; however, a new issue was identified as the advance directives were all signed by the GP only, and the RN interviewed could not clarify the validity of the requests. The RN confirmed that staff education related to this area was planned to be undertaken early in the new year.</p>
<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>Residents were informed of their rights to the advocate of their choice during the admission process and by clearly displayed documentation at the facility. Residents, family/whanau and staff were aware of a resident's right to access a support person at any time.</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>Residents were encouraged to maintain links with their family/whanau and friends at any time, as the service has open visiting hours. Residents also continued to access community services of their choice, such as those described during resident and family/whanau interviews. Examples given related to attending off site church service, organised activities and cultural celebrations.</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 service had an up-to-date complaints register which identified the date of the complaint and the actions taken and when resolved. Complaints management was used to improve services as appropriate. The service had an external complaint since the last audit made to the DHB and this has now been resolved.</p> <p>The residents and family/whanau interviewed confirmed they have had the complaints procedure explained to them and they understand and know how to make a complaint if required. They stated they would feel comfortable to make a complaint at any time. The information given to</p>

		<p>all residents and family/whanau upon admission includes complaints forms and a full explanation of how the system works. Advocacy information was also included in the admission booklet. Both the complaints and advocacy information was on full display at the entrances to the facility.</p> <p>Interviews with care staff confirmed awareness of their responsibility to record and report any complaints they may receive.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Resident and family/whanau members interviewed confirmed that they were informed of their rights. Information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service were displayed and accessible to residents. The admission procedure included discussion and clarification around the Code and residents' rights to use advocacy services.</p> <p>The prospective owners interviewed verbalised their understanding of residents' rights and the need to ensure these were met at all times.</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>	FA	<p>Procedures related to the prevention of abuse and neglect were understood by staff and implemented into everyday practice. This included appropriate management of residents' spirituality and sexuality. Interviews with staff, residents and family/whanau members verified there were no concerns expressed related to abuse or neglect.</p> <p>Service provision was observed to be delivered in a manner that respected residents' dignity, privacy and independence and was responsive to their needs, values and beliefs. Single occupancy bedrooms allowed privacy for residents and their visitors at any time and ensured belongings were safely stored. Staff were observed to close doors when undertaking personal cares and verbalised their understanding of residents' rights, including privacy.</p> <p>Residents had access to visitors of their choice and were supported to access community services.</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>Residents who identified as Maori have their needs identified upon admission. Their cultural needs were identified in the care planning process as was confirmed in the review of four residents' files. At the time of audit there were no residents who identified as Maori but staff confirmed whanau relationships and involvement in care planning and delivery were recognised through the implementation of the 'Te Whare Tapa Wha' model of care.</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>Residents received culturally safe services which recognise and respect ethnic, cultural and spiritual values and beliefs. This was confirmed by family/whanau and residents interviewed. Residents' specific cultural, spiritual, values and beliefs were documented in the care plan, to ensure their needs were met. There was evidence that residents with specific cultural needs have these met. This was described in one of the care plans reviewed and confirmed in interview by the resident and their family/whanau.</p> <p>Residents access spiritual support at regular church services offered at the facility and from the community if required. Open visiting policy allowed family/whanau and visitors of residents choice to visit when able. The prospective owners do not intend to make any changes to services offered.</p> <p>Evidence to support the above findings was observed and sighted in files reviewed and staff training records.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents were free from all forms of discrimination, coercion, harassment and exploitations as confirmed during staff, resident and family/whanau member interviews.</p> <p>Orientation/induction processes informed staff on the Code of Rights and the code of conduct. The staff job descriptions, employment agreement, and company policies provided clear guidelines on professional boundaries and conduct, and informed staff about working within their professional boundaries. There were processes in place</p>

		which would be implemented should a formal disciplinary procedure be required related to an employee's breach of conduct. The prospective owners understood this process.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Fencible Manor provided an environment that encouraged good practice. Staff education covered the key components of service delivery which allowed staff to deliver services in a manner that met residents' requirements, as confirmed by resident and family/whanau interviewed and observations on the day of audit.</p> <p>Residents' files reviewed show how any issues or concerns related to resident care were managed. The general practitioner (GP) interviewed confirmed the service sought prompt and appropriate medical interventions when required and that medical requests were followed up as instructed.</p> <p>The registered nurse (RN) confirmed that allied staff are involved in residents' care when necessary. The prospective owners confirmed service delivery will remain unchanged.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family/whanau members interviewed confirmed communication with staff at Fencible Manor was open and effective to meet the principles of open disclosure. Residents and/or their family/whanau were consulted and informed of any untoward event or change in care provision and included in care reviews as confirmed in clinical documentation sighted in residents' files reviewed. An area identified for improvement in the previous audit has been fully addressed.</p> <p>No residents at Fencible Manor required interpreting services. Access to interpreters was available. This process was understood by the prospective owners.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are	FA	The business plan included the decisions made related to policy and budgeting. It identified the organisation's mission statement, vision and

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>philosophy and showed the organisation's planning process to meet residents' needs. The quality policy statement identified the mission of the organisation and the procedures undertaken to achieve the mission statement. Actions described include the use of quality programmes and procedures, identification of hazards, staff training and education, data reporting of incidents/accidents, infections and internal audit results to identify trends and improve services. The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. The goals are reviewed annually using the quality monitoring system.</p> <p>The service was managed by a nurse manager who is a registered nurse. The owner has over nine years of experience in the management of aged care services. The manager's job description sighted described the authority, accountability, and responsibility for the provision of services. The manager had completed over 8 hours education in the previous 12 months related to the management of aged care. This included attendance at aged care study days, local education available, first aid recertification and specific education related to aging processes and illness. The manager was support by an assistance manager and the owner.</p> <p>The staff and GP reported the service was well managed. The owner interviewed had full confidence in the experience and skill of the both nurse manager and assistant manager to effectively perform their roles.</p> <p>The prospective owners interviewed are the current nurse manager (NM) and her husband. The NM graduated in 2010 and has worked in surgical and other aged care facilities. She has knowledge of the requirements of aged care and will be supported by the current owner. Her husband has no previous experience in aged care but has experience in business and administration. On interview the NM reported knowledge of client entry assessment processes, consent, open disclosure and staff education requirements.</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</p>	<p>FA</p>	<p>During a temporary absence of the manager a suitably qualified RN was able to perform the NM role. The NM reported that she has a replacement RN to take on the role of manager during her temporary</p>

<p>provision of timely, appropriate, and safe services to consumers.</p>		<p>absence. The NM maintained a professional portfolio. She has been employed at Fencible Manor Rest Home for 18 months and had previously worked in aged care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Family and resident feedback was sought through satisfaction surveys to ensure the service provided is appropriate for residents. The monitoring of the clinical, operational, financial and staffing risks occurred through an internal auditing system. There were monthly reports at staff meetings which included all legislative requirements. Information was taken to the staff meeting as identified in minutes sighted. Data was trended and trends analysed by the management team and corrective action plans developed as required. Results of trends and required corrective actions were discussed at monthly staff meetings as confirmed by staff and management interviews and in minutes sighted.</p> <p>Interviews with caregivers and the NM confirmed they were aware of quality systems and that they were informed of audit results at staff meetings. Staff confirmed that open discussion occurred related to all quality and risk issues and meetings were used to measure quality improvement outcomes. The prospective owners are not planning any changes to risk and quality management systems.</p> <p>The organisation had an up to date business plan which included a quality and risk plan and identified actual and potential risks for rest home level of service. Minimisation strategies have been put in place as required. Staff education included risk management processes. Interviews with clinical staff confirmed their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards is set out in the information book given to all residents and family/whanau. The previous area for improvement has been addressed.</p> <p>Residents and family/whanau interviewed confirm any issues that were raised were addressed promptly and that they were kept informed of the outcome. Satisfaction survey results confirm interview findings.</p> <p>There is an ongoing area requiring improvement relating to document review and control, as policies and procedures were not being kept up</p>

		to date as part of the document control system.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The staff and management interviewed understood their statutory and/or regulatory obligations in relation to essential notification reporting. The correct authority is notified where required. The manager reports that there have been no serious incidents that have required essential notification.</p> <p>The service used health and safety report forms to document adverse, unplanned or untoward events or near misses. The monthly reports of the incidents and accidents recorded the number of incidents and accidents. Shortfalls identified opportunities to improve service delivery and manage risk; this included, for example, implementing strategies at the increased times of falls. Results of incident and accident trend analysis were discussed at the staff and management meetings and reports presented to the owners as appropriate (eg, if there was serious injury).</p> <p>Interviews with caregivers and the NM confirmed their understanding of the need to document all adverse events.</p> <p>The residents and family/whanau members interviewed, and documentation sighted on incident/accident forms in residents' files, confirmed family/whanau were kept well informed of their relatives' care requirements and were contacted appropriately by the service if there were any concerns.</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>	PA Low	<p>Documentation Review: Human resources policies describe good employment practices that meet the requirements of legislation. Ongoing training is provided to ensure staff comply with health and Safety standards.</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers. The manager ensures that staff who require practising certificates have them validated annually. Practising certificates are sighted for all staff who require them.</p>

		<p>Human resources practices are implemented as per policy requirements and staff record reviews identify that staff are employed to undertake roles appropriate to their skills and knowledge. Documentation sighted includes referee checks and police vetting for newly appointed employees as appropriate.</p> <p>The service undertakes regular in-service staff education which identifies that requirements are met. Staff confirm during interview that they have access to external education/training and this is highlighted in four of four staff file reviews. Each staff member has a clearly identified education attendance record. Staff appraisals are up-to-date and used as a method for staff to identify educational needs, wants and interests. Education sighted covers all key components of service delivery..</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>The service has a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet all their identified needs and contractual requirements with the Counties Manukau District Health Board (CMDHB). The care staff rostering and skill mix was based on clinical indicators for safe staffing in aged care. The NM is onsite Monday to Friday and suitably qualified staff provided an on call service.</p> <p>The prospective owners reported on interview that they will be continuing with the same service provider availability system.</p> <p>The GP interviewed confirmed there was a system in place for after-hours medical services. Interviews with caregivers (one who works morning and afternoon shifts) confirmed that staffing levels and skill mix allowed all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. This was supported by interviews undertaken with the residents and family/whanau members.</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>Personal and medical information has been entered into residents' files in a timely manner. Each individual resident's file recorded all relevant information accurately. The residents' records contained legible and dated information with the time of entry and the designation of the staff member. Integrated notes on the resident's progress were completed</p>

		<p>by care staff at least daily. A 'sign off' by the GP that the resident was stable and only required three monthly visits was made each visit as sighted in the four files reviewed.</p> <p>All records, including achieved files, were securely stored and not accessible to the public.</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>Entry criteria and processes were documented and the Needs Assessment and Service Co-ordination (NASC) agency use this information to refer rest home level care residents. If a phone enquiry was received from someone who had not been assessed by the NASC, they were advised to contact their GP or the local NASC agency.</p> <p>Family/whanau members interviewed confirm they were aware of the level of care offered and that the entry processes were fully explained to them. The admission agreement was provided, enabling an opportunity to seek guidance/legal advice. The prospective owners verbalised their knowledge related to the level of care offered by the service and the need for NASC assessments to occur. They are also aware of what items can be included in ongoing charges as they are set out in the admission agreement. For example, the only items that are currently on charged are continence products for residents who wish to use products of their choice which are not supplied.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer was managed in a planned and co-ordinated manner, with documented concerns clearly shown to minimise risk. As verified during staff interviews, family/whanau were always informed of any exit, discharge or transfer. There was a specific transfer/discharge form that recorded all the relevant information needed for transferring a resident safely. Staff reported that a verbal handover was given when practicable. If a resident required acute general hospital admission the form used has been approved by the DHB and indicates all known risk factors.</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 High</p>	<p>Policy and procedures described current practice related to medicine management. Not all aspects of policy were followed by the facility and there was evidence of staff prescribing and dispensing medicines from unauthorised bottles. The medicine forms reviewed identified that the GP reviewed medicines at least three monthly if the resident was stable, or sooner as required. Review, storage, disposal and reconciliation processes were met. There were no residents who self-administer medicines at the time of audit.</p> <p>Medicines for residents were received from the pharmacy in the robotic delivery system. All staff who administered medicines do not hold current medication competencies.</p> <p>Controlled drugs when in use were stored in a separate locked cupboard and checked by two nurses when being administered. One medication stocktake was not recorded accurately.</p> <p>Residents' photos, allergies and sensitivities were recorded on the medicine chart. Staff sample signatures were documented. All medicine charts reviewed had fully completed medicine prescriptions and had signing sheets, including approved abbreviations when a medicine had not been given.</p> <p>Medication errors were reported to the RN and recorded on an incident form. Incident forms recording drug errors were few and evidenced errors managed appropriately.</p> <p>The RN reported that the service has no standing orders in place. There was an example noted of a medication being given daily over a long period of time but this remained charted as an 'as required' pro re nata (PRN) medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food, fluid and nutritional requirements of the residents was provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu sighted. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complied with current legislation and guidelines.</p>

		<p>A dietary assessment was undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements were known to the cook and accommodated in the daily meal plan.</p> <p>There is evidence to support sufficient food was ordered and prepared to meet the resident's recommended nutritional requirements, as confirmed by resident, staff and family/whanau members interviewed.</p> <p>The chef confirmed that all aspects of food productions, preparation, storage, delivery and disposal were undertaken to meet current good practice standards and safe food handling processes. Staff hold up to date safe food handling certificates. Fridge and freezer temperatures were monitored daily and records sighted verified temperatures were within accepted parameters. An area identified for improvement in the previous audit has been addressed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services 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 owner confirms that when entry to the service is declined, the reason for declining entry is communicated to the referrer, resident and their family/whanau in a timely manner. Where requested, assistance was given to provide the resident and their family/whanau with other options for alternative health care arrangements or residential services information.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The service used recognised assessment tools. The service was in the process of converting all residents onto the interRAI assessment programme. This process has been completed for five residents and the nurse manager (who is the prospective owner) confirmed that as each resident's assessment is updated interRAI will be used.</p> <p>Information gathered from the assessments undertaken was used to inform the residents' care plans which directed the ongoing care requirements to meet their needs. Resident and family/whanau input was shown in documentation and confirmed during interview.</p> <p>Staff interviewed confirmed they used observation and the information in</p>

		the care plan to deliver the care the resident required.
<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>The care plans at Fencible Manor were developed in consultation with the resident and/or family/whanau, as confirmed during interviews, to ensure they were resident focused. They described the required supports needed for residents to meet their goals. Specialist input was sought as required. Staff interviewed confirmed the resident care plan was updated to show the current care required.</p> <p>Evidence of the care provided was sighted in files reviewed. Progress notes, activities notes, medical and allied health professionals' notations were clearly written, informative and relevant to the care provided. Any change in care required was written in progress notes and entered onto the resident's care plan and verbally passed on to those concerned. This included short term care planning for issues, such as infections, which only existed for a short period.</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>	FA	<p>Files reviewed identified that assessment findings were in line with planned interventions shown on residents' care plans. Interventions were detailed, accurate and met current best practice standards.</p> <p>Observations and interviews with staff, residents and family/whanau verified the provision of care that met all aspects of residents' needs to gain their desired outcome, whenever possible. The service maintained sufficient supplies of equipment such as continence and wound care dressings to meet residents' needs.</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>	FA	<p>A planned activities programme was sighted that facilitated the maintenance of the residents' strengths and interests as identified in the activities assessment. Activities reflected ordinary patterns of life and included community and family/whanau involvement where appropriate. Residents activity assessments were undertaken, updated or reviewed at least six monthly. The service maintains a summary of the resident's responses to the activities, level of interest, and participation. This</p>

		<p>identifies good attendance at activities offered.</p> <p>Resident and family/whanau members interviewed voiced their satisfaction with the activities programme offered. The activities co-ordinator reported that resident and family/whanau feedback was sought to identify if the activities are meeting all residents' needs and wants. An issue identified for improvement in the previous audit has been addressed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care was evaluated daily and reported at least daily in the progress notes. If any change was noted this was reported to the RN and discussed at the handover between shifts.</p> <p>As identified in residents' files reviewed, care plan evaluations measured the degree of a resident's response in relation to desired outcomes and goals. These occurred six monthly or as a resident's needs changed. Where progress was different from expected, the service was seen to respond by initiating changes to the service delivery plan.</p> <p>Resident and family/whanau members interviewed verified they were included and informed of all care plan updates and changes.</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>	FA	<p>Residents were supported to access or seek referral to other health and/or disability service providers. The process was described in policy and implemented by staff. The GP interviewed confirmed that all referrals were followed accordingly and that family/whanau and the resident were kept fully informed. This was confirmed during resident and family/whanau members interviewed and in documentation sighted in residents' files.</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</p>	FA	<p>The chemicals were observed to be securely stored in the laundry, cleaners' cupboard and sluice rooms. The laundering of the linen was conducted on site as part of the caregivers' duties. The staff who participated in the laundry and cleaning reported that they follow a</p>

<p>substances, generated during service delivery.</p>		<p>documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complied with current legislation.</p> <p>There were appropriate personal protective equipment (PPE) and clothing in the laundry, sluice and cleaning areas. The caregivers interviewed reported that they have had training in the handling of waste or hazardous substances, which was conducted by the external agency as part of the ongoing in-service education programme.</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>There were adequate numbers of accessible toilets/showers/bathing facilities, conveniently located and in close proximity to residents' rooms. There were sufficient toilets and bathrooms to service the residents. The toilets and showers were clearly identified with signage of engaged/vacant privacy notices. The bathing and showering facilities sighted have wall and floor surfaces that are maintained to a standard to provide ease of cleaning and compliance with infection control guidelines. The residents and family/whanau reported satisfaction with the toilets and shower facilities.</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 sighted are of a suitable size for the needs of the resident. The rooms sighted have adequate space to allow the resident and staff to move safely around in the rooms. Residents who use mobility aids are able to safely manoeuvre with the assistance of their aid within their room. As observed at the time of audit residents could freely move around the facility. The residents and family/whanau interviewed reported satisfaction with their rooms and all stated that they really appreciated the size and outlook of the rooms.</p>
<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</p>	<p>FA</p>	<p>There are two lounges and one dining area in the facility. The rest home has a quiet room if required. The lounge and dining area are separate and activities in these areas do not impact on each other. The residents' rooms also have space for family/whanau if the resident wishes to entertain in their room. The residents and family/whanau</p>

needs.		interviewed reported satisfaction with the lounge and dining facilities.
<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>The laundering of the linen is conducted on site by care staff as part of their role. The laundry has a dirty to clean flow. The cleaning staff and caregivers interviewed who assist with laundry services report they have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. The laundry and cleaning equipment observed at the time of audit is stored in safe and hygienic areas. The residents and family/whanau interviewed report satisfaction with the cleaning and laundry service.</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>The service had adequate emergency supplies in the event of an emergency or infection outbreak. The cook reported there is a least two weeks supply of food at all times. The service had stores of drinking and non-drinking water for emergency. There was a civil defence kit with additional food, first aid and emergency supplies. In the case of mains failure the service has access to emergency lighting, and BBQ for cooking.</p> <p>All residents' rooms, bathrooms and lounge areas had a call bell system installed. The call bell system had an audible alert, a light that comes on above the door if the call bell is activated and panels in the corridors. The call bell system is monitored for response times, with no ongoing issues indicated for the timely response to call bells. The residents and family/whanau reported that the call bell was answered in a timely manner.</p> <p>The orientation and ongoing training records sighted evidence the staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The clinical staff interviewed demonstrated knowledge on responding to emergency situations. The registered nurse had a current first aid qualification and there is at least one staff member on duty at all times that has the current qualification.</p> <p>There have been no changes to the layout of the service that have required changes to the approved evacuation scheme. The service</p>

		<p>conducts six monthly evacuation training, with the last drill conducted May 2014. The service then conducts a fire and safety questionnaire for staff to complete.</p> <p>The service identifies and implements appropriate security arrangements relevant to the residents at the rest home. The afternoon staff are required to close and lock the external windows and doors before it gets dark. The service has external security lighting. The clinical staff interviewed reported that they feel safe and secure when working afternoon and night shifts. The residents and family/whanau interviewed reported they felt safe and secure at night.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention control programme enables the provider to control the environment safely. Reporting lines were clearly defined. The programme covered the monitoring, reporting and analysing of data. Corrective actions are put in place if infection rates rise. Good infection control practices were observed during audit. It was the responsibility of the infection control coordinator (who is the RN) to ensure appropriate resources were available for the effective delivery of the infection control programme. It was the responsibility of all staff to adhere to the procedures and guidelines in the infection control programme and policy when carrying out work practices, which identified acceptable standard definitions. An area identified for improvement in the previous audit is now fully met.</p> <p>The infection control coordinator reported monthly infection rate data and presented a report at monthly staff meetings. This was supported in staff minutes reviewed and during staff interviews. The current owner was notified of any serious infection related issues. The infection control programme was reviewed in October 2013.</p> <p>The prospective new owners stated they were considering purchasing an infection control programme from an approved provider.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	FA	<p>The documented infection control programme implemented was appropriate for the size and services offered at Fencible Manor. The infection control coordinator and observation verified there were enough</p>

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>resources to implement the programme. Implementation of the infection control programme was confirmed by data collection records, corrective actions taken when infection numbers increased and staff interviews which confirmed their knowledge and understanding of infection control matters as reported at staff meetings.</p> <p>Education records sighted verified the infection control coordinator was experienced in most infection prevention and control matters and can access more expertise from the DHB as required.</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>	<p>FA</p>	<p>The service maintained written policies and procedures for the prevention and control of infections which comply with legislation and current accepted practice standards. The policies have been gathered from various sources but cover all requirements. (Refer comments in criterion 1.2.3.4). Staff interviewed stated they understood the policies in place and that they were able to implement all procedures.</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>	<p>FA</p>	<p>Staff have received orientation and ongoing education in infection control and prevention as verified by staff education records and staff interviews. The content of the education sighted was relevant to the services provided and understood by staff. A record of attendance was maintained. Education for residents occurred in a manner that recognised and met the residents' and the family/whanau communication styles, as verified during interviews.</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>	<p>FA</p>	<p>The organisation demonstrated that the surveillance data collected and analysed was appropriate to the residents and complexity of the services offered. Data was collected each month related to each identified infection and analysed to identify any significant trends or possible causative factors. If the number of any type of infection increased dramatically the service implemented corrective action planning processes to address this. Incidents of infections were presented at staff meetings. This is confirmed in documentation sighted and during staff interviews.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety.</p> <p>There were no current residents that have restraint or enabler use. The caregivers and one RN interviewed demonstrated understanding that enabler use is voluntary and the least restrictive option.</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 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	The service gained written consent related to advance directives. In the four residents' files reviewed the form is signed by the GP. Education related to informed consent was scheduled to occur next year by an approved provider and will cover advance directives.	During interview with the RN, who is one of the prospective owners, they could not verbalise what constitutes valid advance directives.	<p>Ensure all staff have a clear understanding that advance directives can only be acted on where valid.</p> <p>180 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	Some procedures and policies were outdated, in a range of different versions and needed reviewing to ensure compliance with the required standard. The NM reported on interview that the processed required to be improved.	Policies and procedures used were not best practice and were outdated.	<p>Ensure all procedures and policies are compliant with best practice.</p> <p>180 days</p>

<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Two of five staff files did not contain up to date job descriptions. The NM and owner reported on interview that it was an area that required improvement.</p>	<p>Staff files did not contain up to date job descriptions.</p>	<p>Ensure all staff files contain current job descriptions,</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA High</p>	<p>Fencible Manor has a documented medicine management system in place. Observation identified that most medications were delivered in individualised resident packed rolls. Medication was safely stored, with a minimum of three monthly reviews undertaken by the GP. If medication is no longer required it was sent back to the pharmacy for appropriate disposal. There was evidence of staff dispensing medication into non-pharmacy containers. The documentation which identified controlled drug medication sent back to the pharmacy was not accurate.</p>	<p>Warfarin was clearly prescribed according to blood test results but had been dispensed by staff into bottles with handwritten labels for each resident. The RN was not aware that this was an unsafe practice.</p> <p>Controlled medications sent back to the pharmacy were shown in the controlled drug register but entries for one medication was entered into the wrong column which indicated an incorrect number of medications on site.</p>	<p>Ensure all aspects of medicine management are implemented to manage the safe and appropriate dispensing, prescribing, review and reconciliation of all medications to comply with legislation, protocols and guidelines.</p> <p>30 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>	<p>PA High</p>	<p>Service providers responsible for medicine management have undertaken competency testing on previous occasions. Currently they are not up to date. The medication competency which staff complete does not include anything related to the administration of insulin or warfarin. As there is not a RN on duty for all shifts the caregivers who administer medications require this knowledge to</p>	<p>Caregivers and the RN have not undertaken a medication competency since September 2013. The documented medication competency sighted did not meet all the requirements of current best practice guidelines to include specific insulin management.</p>	<p>Ensure that service providers responsible for medicine management have current competencies to manage all functions required of them to manage resident care safely.</p> <p>30 days</p>

		undertake the role safely. There were no medication incidents reported related to insulin or warfarin.		
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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.