# Nicolson Rest Home Limited - Nicolson Rest Home Limited

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Nicolson Rest Home Limited

**Premises audited:** Irwell Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 January 2017 End date: 20 January 2017

**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:** 38

# 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 |
|  | 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

Irwell Rest Home is privately owned and operated and cares for up to 60 residents requiring rest home level care. On the day of the audit there were 38 residents.

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

The service continues to implement a quality and risk management programme. Progress with the quality and risk management programme is being monitored through the monthly quality improvement meetings.

The service has addressed the one finding from the certification audit relating to one aspect of medication documentation.

This audit has identified that one improvement is required around wound assessment and evaluation.

## Consumer rights

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| 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. |

Communication with residents and families is appropriately managed and recorded. Complaints are managed and residents and families are aware of the complaints process.

Residents and relatives interviewed state that the staff and management are approachable and available. Residents meetings are held monthly, providing an opportunity to feedback on the services. Families interviewed confirmed that they are informed of changes in health status and incidents/accidents.

The service has in place an implemented complaints policy and procedure that aligns with Code 10 of the Code of Rights. Complaint forms are available at the entrance of the service.

## Organisational management

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| 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. |

The quality and risk programme describes Irwell’s quality improvement processes. Progress with the quality and risk management programme has been monitored through the monthly quality improvement meetings. Resident/relative meetings have been held monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2016 has been completed and 2017 has commenced. Newly employed staff complete an orientation programme. There is an education planner in place that includes compulsory training for aged care staff. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff on duty to safely deliver care within a timely manner.

## Continuum of service delivery

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

Assessments, care plans and evaluations are completed by a registered nurse within the required timeframes. Care plans describe interventions to support resident current needs. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication are prescribed and stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared onsite. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

The building holds a current warrant of fitness.

## Restraint minimisation and safe practice

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| 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. |

Irwell Rest Home has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. There were no residents requiring the use of restraints or enablers.

## Infection prevention and control

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| 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. The information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 1 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Systems and processes have been in place to ensure that any complaint received is managed and resolved appropriately. Four complaints were received in 2016. The four complaints reviewed showed the appropriate acknowledgement, investigation and resolution within the required timeframes. All complaints are discussed at staff meetings. Residents and family members advised that they are aware of the complaints procedure and how to access forms.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed stated they were welcomed on entry and were given time and explanation about services and procedures. The owner/managers have an ‘open door’ policy. Relatives interviewed confirmed that the staff and management are approachable and available. The owner/managers live onsite and are available to meet with residents and families after hours if required. There is a residents meeting held monthly with opportunity for feedback on the services. Annual resident, relative and food satisfaction surveys are completed that provide feedback on all areas of the service. Staff complete a self-directed questionnaire on effective communication. Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Irwell Rest Home is privately owned and operated. The owners live onsite. The owner/managers are supported by one fulltime and one part-time registered nurse. The service provides care for up to 60 residents at rest home level care. On the day of the audit, there were 38 residents.At the time of the audit there was one resident on respite, one resident on a long-term chronic condition contract and one resident who had recently been assessed as hospital level care and was awaiting transfer to another facility. All other residents were under the ARC contract.The current business plan including service goals has been implemented and all goals for 2016 were documented as achieved. The 2017 business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The owner/managers are responsible for the operational and financial aspect of the business. The owner/managers are qualified caregivers who have maintained at least eight hours of management training per year. The business is a member of the NZ Aged Care Association and attends provider meetings and district health board forums providing networking opportunities.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk programme describes Irwell’s quality improvement processes. Progress with the quality and risk management programme has been monitored through the monthly quality improvement meetings. The quality improvement meetings cover matters arising from the staff and resident meetings, health and safety, complaints, accidents/incidents and infection control, internal audits and survey results and outcomes. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant. Resident/relative meetings have been held monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. This data is analysed for trends and graphed, with graphs displayed in staff areas. The internal audit schedule for 2016 has been completed and 2017 has been commenced. Areas of non-compliance identified at audits have a corrective action plan. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed two yearly. Falls prevention strategies are implemented for individual residents. Staff interviewed state they are well informed and receive quality and risk management information including accident/incident graphs and infection control statistics.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Samples of 12 resident related incident reports for January 2017 were reviewed. All of the incident reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. Five staff files reviewed (one RN, three caregivers and one activities coordinator) included all appropriate documentation. A copy of practising certificates is kept. There is an orientation programme that includes organisational structure and policies and general information for staff. Staff are orientated to their area of work and complete competencies relevant to their role. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. Annual appraisals are conducted for staff.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Irwell has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident’s needs on different shifts and for both floors of the facility. The (owner/managers) are both qualified caregivers, live onsite and are available on call. The registered nurse/care lead works 40 hours per week, another registered nurse works 16 hours per week. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Six caregivers, five residents and three family interviewed, advised that sufficient staff are rostered on for each shift.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. The service has implemented an electronic management system. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed for correctly for the sample of 10 electronic medication signing charts reviewed. The registered nurses and senior caregivers administer medicines. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile the delivery and this is documented. There was evidence of three monthly reviews by the GP. Medications are prescribed and charted by the GPs on the electronic medication management system in line with guidelines including indications for use for ‘as needed’ medications. The service has addressed this previous finding around transcribing of medications. There were no residents self-administering medicines. Standing orders are not in use.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service is provided by trained staff in a well-appointed kitchen. The kitchen is centrally located adjacent to the main dining room. A tray service is provided to residents who prefer to have meals in their rooms. Food service manuals are in place to guide staff. A resident dietary profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen is able to meet the needs of residents who require special diets and the cooks work closely with the registered nurses. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Caregivers follow the care plans and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral. Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Monitoring forms are in place for restraint use, behaviour management, and fluid balance charts, turning charts and pain management. Wound documentation is available and includes assessments, management plans, progress and evaluations. However, not all wound assessments were fully completed to include the stage of wound and a wound assessment was not evidenced completed for each current wound. There were five residents with wounds including one resident with two stage-2 pressure injuries; one resident with a stage-1 pressure injury, one resident with an extensive scalp lesion, one resident with two skin tears; and one resident with a wound following surgical interventions. Wound evaluations have been completed but did not contain enough detail to monitor progress towards wound healing. The RNs have attended wound care training.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is an activity coordinator who facilitates the activities programme for residents. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed for the resident files sampled. The activities programme reflects the residents’ cognitive and physical abilities. Activities are provided for each morning and afternoon Monday to Friday. Group activities reflect ordinary patterns of life and include planned visits to the community. The facility has a van which is used for weekly resident outings. Residents also independently access interests in the local community. The local SPCA visits the facility and provides pet therapy. The local Brownie pack visits the facility and entertainers visit monthly.Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews document progress toward goals. There is at least a three monthly review by the GP. Changes in health status are documented and followed up. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility has a current building warrant of fitness which expires on 23 November 2017. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. A registered nurse is the infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the owner/managers. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service currently has no residents on restraint or enablers. |

# 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)** |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | All five resident files reviewed had a care plan in place. The respite resident had an appropriate short-term care plan in place. One long-term resident with increased needs has recently been reassessed for a higher level of care and has an appropriate care plan in place which addressed the residents increased needs around assistance with personal cares, pain management and mobility. A review of the roster evidences there are two staff members on duty at any one time to assist with the residents’ increased needs.Pressure injury care was provided for all residents requiring pressure injury prevention. On the day of audit, there were six wounds, including two residents with pressure injuries. Three of six wounds had fully completed documentation. Short-term care plans were in place for all wounds and acute conditions.  | (i) Not all wounds were evidenced to have an individual wound assessment completed. Two residents had more than one wound recorded on each form, so that wounds were unable to be evaluated separately. (ii) Evaluation in wound management plans reviewed documents “dressing changed” there was no detailed evaluation towards progress of wound healing documented on three of six wound management plans reviewed. (iii) Wound assessment for three of three pressure injuries reviewed did not document the stage of the pressure injury. | (i) Ensure an individual wound assessment and treatment plan is completed for each wound. (ii) Ensure that wound evaluations document the progress towards wound healing. (iii) Ensure wound assessments for pressure injuries document the stage (classification) of pressure injury on completion of initial wound assessment.60 days |

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

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

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

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

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| No data to display |

End of the report.