

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

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

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

The specifics of this audit included:

Legal entity:	Clair House Limited
Premises audited:	Claire House Aged Care Facility
Services audited:	Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 17 August 2017 End date: 18 August 2017
Proposed changes to current services (if any):	To remove residential disability- physical from their current certification
Total beds occupied across all premises included in the audit on the first day of the audit:	51

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
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Claire House Aged Care provides rest home and residential disability – physical level care for up to 54 residents. On the day of the audit there were 51 residents. The rest home has been owner/operated for 32 years.

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.

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 on-going quality improvement.

The owner/operator is non-clinical and supported by two registered nurses experienced in aged care and a quality coordinator.

The service has achieved continuous improvement ratings around good practice, food services and reduction of urinary tract infections.

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.

All standards applicable to this service fully attained with some standards exceeded.

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. Complaints 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 32 years. She is supported in her role by a quality coordinator and two registered nurses. Quality management processes are reflected in the businesses plan's goals, objectives and policies. There is a 2016-2018 business plan in place. A risk management programme is in place, which includes incident and accident reporting and health and safety processes. Staff document incidents and accidents. 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. The service has an annual training schedule for

in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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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 reflect legislative requirements and guidelines. 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.
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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.
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The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. At the time of the audit, the service had no residents using restraints or enablers. Staff have received training around restraint minimisation and management of challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. 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.

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	2	43	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with ten care staff (two registered nurses (RN), seven healthcare assistants (HCA) and one activities coordinator) confirmed their familiarity with the Code. Eight residents and two family members interviewed confirmed the services being provided are in line with 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 give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. All eight resident files (four rest home, one resident under long-term chronic health condition, one younger person, one under ACC funding and one under mental health funding) resident contained signed general consents.</p> <p>Resuscitation status had been signed appropriately. Advance directives were signed for separately identifying the resident's wishes for end of life care.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where</p>

		<p>appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. The healthcare assistants (HCA) interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Two family and eight residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>Eight resident files reviewed had signed admission agreements.</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>Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service entrance area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. 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. Residents on the YPD contract are engaged in a range of community activities.</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 has a complaints policy that describes the management of the complaints process. Complaint forms are available. Information about complaints is provided on admission. The owner/manager and the RNs operate an 'open door' policy. Residents and relatives confirmed they are aware of the complaints process. Healthcare assistants interviewed were able to describe the process around reporting complaints. There were 15 complaints made in 2016 and seven complaints received in 2017 year to date. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed has been followed up and implemented.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the owner/manager or RN discusses the information pack with the resident and the family/whanau.</p>

<p>Consumers are informed of their rights.</p>		<p>This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is a policy on abuse and neglect and staff received training in October 2016.</p> <p>Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there were no residents that identified as Māori. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	<p>FA</p>	<p>The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. The staff employment process includes the signing of house rules.</p>

other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	<p>The service meets the individualised needs of residents with needs relating to rest home level care. 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, the requirement to attend orientation and ongoing in-service training. The owner/manager is responsible for coordinating the internal audit programme. Monthly staff/quality meetings and regular residents meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the owner/manager and RNs.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. An RN is on-call when not on-site. A house general practitioner (GP) visits the facility one day a fortnight. The service receives support from the local district health board (DHB). Physiotherapy services are provided on site, eight hours per week. A podiatrist is onsite for eight hours every six-weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There is an open disclosure policy in place. Residents are provided with a range of information on admission regarding the scope of service and any items they have to pay for that is not covered by the agreement. An interpreter is provided as required. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Relatives sign a communication sheet to inform the service when and under what circumstances they would like to be informed. Ten incident forms reviewed identify that family were notified following a resident incident. Two family members interviewed stated they were well informed and involved when needed in residents care. 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 residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and can be read to residents who are visually impaired.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	<p>Claire House offers rest home and physical disability level care for up to 54 residents. Contracts include the Aged Related Care Contract (ARCC) and physical disability services under the Young Persons with a Disability (YPD) Contract. The service has confirmed that they wish to remove residential disability from their current certification. Claire House is split into three buildings/villas.</p>

<p>appropriate to the needs of consumers.</p>		<p>Claire House has 16 of 16 residents, Clairemont has 15 of 16 residents, Fleurmont has 15 of 16 residents and Claire Villa has five of five residents. There was one resident under independent funding residing in a boarding house on the site. On the day of audit there were 51 rest home residents in total, including two residents under the younger person contract, four on the Long-Term Support Chronic (LTS-CHC) contract and two residents under the mental health funding.</p> <p>There is a 2016-2018 business plan, quality and risk plan developed which aligns with purpose, mission and values of the business. There was evidence of the annual review of the business plan. The owner/manager is non-clinical and has owned and managed the facility for 32 years. The owner/manager is supported by a quality coordinator and two RNs. One of the RNs has been at Claire House for six years, she is also the assistant manager and the other RN has been in the position for one year. The owner/manager lives in an adjoining property and is available 24 hours a day/seven days a week if necessary.</p> <p>The owner/manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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>	<p>FA</p>	<p>The owner/manager reported that in the event of her temporary absence the RN/assistant manager fills her role with support from the other RN and 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>	<p>FA</p>	<p>A quality and risk management programme is in place. Quality goals were documented in the staff/quality meeting minutes. Policies and procedures are provided by an external consultant and include interRAI procedures. A system of document control is in place with evidence of regular reviews. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. The monthly collating of quality and risk data includes monitoring accidents and incidents, resident satisfaction and infection rates. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement. Staff are kept informed regarding results via staff meetings and during staff handovers. There are annual resident satisfaction, family satisfaction, complaints/advocacy and food satisfaction surveys completed. Any corrective actions were documented and included evidence of implementation and sign off.</p> <p>The quality programme is linked to the annual training plan with extra and impromptu training offered</p>

		as issues are identified. A quality improvement register is maintained and lists the key objectives, interventions and evaluations of the improvements listed. The HCAs state they are fully informed and involved in the quality programme. A health and safety programme is in place, which includes managing identified hazards. Health and safety meetings are conducted each month. The facility has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality/staff meeting. Ten resident related incident forms were reviewed for July 2017. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the owner/manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required.</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>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files (two RNs, two HCAs, one enrolled nurse, one cook and one activities coordinator) reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is an annual education plan being implemented that includes monthly competencies that must be completed by staff. Two of two RNs have completed their interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the owner/manager who works full-time and lives on the premises, there are two part-time RNs employed from Monday to Friday. An RN is on-call when not on-site. The RNs are supported by two enrolled nurses (EN). Healthcare assistants assist the designated laundry staff. Cleaning staff are employed over seven days a week.</p>

experienced service providers.		<p>An activities coordinator is rostered Monday to Friday with an activities assistant working one day (four hours) on the weekends. Staff reported that staffing levels and the skill mix were appropriate and safe. Residents interviewed advised that they felt there are sufficient staffing.</p> <p>Claire House is divided into four houses, Claire House has 16 residents, Clairemont has 15 residents, Fleurmont has 17 residents and Claire Villa has five residents. There is one RN on duty for 32 hours on Monday/Wednesday to Friday and one EN for 40 hours from Tuesday to Saturday in Clair House/Clairemont. There is one RN on duty for 32 hours from Monday to Friday and one EN for 16 hours on Wednesday/Thursday/Sunday in Fleurmont/Claire Villa. The RN's are supported by adequate numbers of HCAs. In Claire House/Clairemont there are four HCAs on duty in the morning and two HCAs on the afternoon shift and on the night shift. In Fleurmont there are three HCAs on duty in the morning, one HCA on the afternoon shift and on the night shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The 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 can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.</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>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>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<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, 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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs, enrolled nurses and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>by the supplying pharmacist. Medications (robotic rolls) are checked on delivery against the medication chart and any discrepancies feedback to the pharmacy. All medications are stored safely in the three villas. Standing orders are not used. Three self-medicating residents had a self-medication competency completed and reviewed three monthly by the GP. The medication fridge is monitored daily. All eye drops were dated on opening.</p> <p>Sixteen pharmacy generated medication charts were reviewed. 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 does 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>CI</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 June 2017. 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. A comprehensive food service survey was undertaken in February 2017 which initiated changes to the menu and increased resident satisfaction with meals. 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. 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>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>	<p>FA</p>	<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 communicate 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>	<p>FA</p>	<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 on-going 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>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<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 alters, the RN initiates a review and if required, GP or nurse specialist 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. A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for two skin tears and one lesion. There is access to a wound nurse specialist and district nurses for advice for wound management.</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.</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 from 10am to 3.30pm per day Monday to Friday to coordinate and implement an activity programme that meets the recreational needs of the resident groups. The activity coordinator attends on-site in-service and diversional therapy group meetings. An activity assistant provides activities on Saturdays.</p> <p>Activities take place in the larger villa three times a week and in the smaller villa twice a week. Residents from the three villas on-site are encouraged to attend the daily programme. Volunteers and nursing students are involved in implementing aspects of the programme. Activities are meaningful and include (but not limited to); 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. A van driver from Age Concern provides four weekly outings into the community. 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 regards to shopping, individualised activities and interests.</p> <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 and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>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. On-going nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or</p>	<p>FA</p>	<p>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.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents.</p>

referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		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 two main villas (Claire House and Fleurmont villa). Personal protective clothing is available for staff and was observed being worn by staff 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 for their purpose.	FA	The three separate care villas (Claire House, Fleurmont villa and the five bed villa) all have a current building of fitness that expires 30 September 2017. There is a maintenance person employed for seven hours per week and on-call for urgent facility matter. A reactive and planned maintenance schedule is in place 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. 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. 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.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal	FA	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.

hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	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 personalize their rooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	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 for the residents. Communal areas are easily accessible to residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	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>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	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 25 May 2017. Civil defence supplies (3 x wheelie bins) are available. There is alternative gas heating and cooking (2 x BBQs and 2 x gas cookers) available. Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency. There is 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

		<p>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>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Some bedrooms' rooms on the ground floor have doors that open out onto individual decks. All bedrooms have adequate natural light.</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 responsibility for infection control is shared between the two RNs. Responsibility for infection control is described in their job descriptions. The infection control coordinators oversee infection control for the service and are responsible for the collation of infection events. The infection control programme has been reviewed annually.</p> <p>Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. There have been no outbreaks.</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>	FA	<p>The infection control coordinators have both attended infection control and prevention education provided by an aged care educator. 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</p>	FA	<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 an aged care consultant and the newly purchased</p>

<p>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>policies were implemented August 2016. Pandemic kits are held within each villa.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<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. Resident education is expected to occur as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance 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>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. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified and quality initiatives are discussed at staff meetings (minutes sighted). Staff also receive a monthly newsletter that includes surveillance data. Benchmarking occurs against similar facilities through Healthcare Help. The service has been successful in reducing urinary tract infections below the benchmark indicator for UTIs. The GP reviews antibiotic use at least three monthly with the medication review. Systems are in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the HCA and nursing staff confirm their understanding of restraints and enablers. At the time of the audit, the service had no residents using restraints or enablers. Staff training around restraint minimisation and management of challenging behaviours last occurred in September 2016.</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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Claire House has an accessible communication process and link between residents and staff. The service encourages its residents and their families/whanau to contact and communicate openly with staff providing personal confidence in the delivery of care. A goal for Claire House is to ensure that all residents feel they are receiving sufficient time, communication and support from the registered nursing staff.</p>	<p>Residents expressed concerns at not seeing the RN throughout the day as much as they preferred, intermittently at the end of 2016 and beginning of 2017. Residents recognised and enjoyed the RN's early morning round but felt that they would like more contact when they wished, to discuss medical or health questions throughout the day with an RN. A resident survey was created and completed in March 2017 to develop a clearer understanding of residents' needs around RN contact and involvement. The 25 residents at Claire House that were surveyed indicated resident satisfaction regarding RN staffing input was at 40% and resident's dissatisfaction regarding RN staffing input was 60%.</p> <p>A quality review meeting, in liaison with the Claire House management team and an external consultant, took place to review the resident concerns from the survey. Staffing levels were reviewed and found adequate at this meeting. However, it was identified that following the introduction of the interRAI assessment tool that the RN's "one to one" contact hours with residents had reduced. Due to the resident survey feedback and results two enrolled nurses (EN) were employed at Claire</p>

			House to help increase the resident “one to one” contact time with the RNs. The analysis of the follow up resident survey (the same 25 residents) completed in June 2017, following the employment of the ENs indicated resident satisfaction regarding contact time with RNs has increased to 80%. Residents’ dissatisfaction regarding contact time with registered staff has reduced down to 20%.
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	The service had been receiving complaints around the meals from November 2016 through to early 2017 relating to the meals. The service implemented a resident survey on the meals and involved them in the development of a new menu. The new menu increased resident satisfaction around meals.	A comprehensive survey was undertaken on the menu with 75% of residents being surveyed after each midday and evening meal for eight weeks. Extra staff hours were allocated to assist with the resident survey over an eight-week period. All comments on the individual meals were collated and changes made to the meal to include resident preferences. A vegetarian option is offered on the menu and changes suggested have improved the protein content and flavours for vegetarian meals. Following consultation with residents and some families the new four-week menu was developed and reviewed by the dietitian. Recommendations from the menu audit have been implemented. A resident survey was conducted one month after the menu was implemented. All residents stated they were very happy with the new menu and there have been noticeable improvements. Individual preferences are being met for example one resident prefers toasted sandwiches for their evening meal and this is accommodated. The service has not received any more complaints regarding the meals.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention	CI	From January to July 2016 the number of UTIs were above the industry average (as per Healthcare Help benchmarking indicators). In August 2016 the UTI rate was 2.5 above the industry average and the service implemented a quality improvement to reduce UTIs.	A quality improvement project was implemented in August to reduce the incidence of UTIs. The action plan included offering regular fluids in a variety of forms including flavoured drinks, lemon flavoured water and a full glass of water with medications at each round. Regular toileting rounds were introduced and there was a focus on educating independent residents on voiding techniques, bladder re-training and hygiene. Staff education also occurred and the use of “stop and watch” forms identified early signs and symptoms that could be treated with interventions such as oral sachets. Due to improved toileting regimes there was a reduction in the use of continence products. All of the practices put in place were effective in reducing UTIs in September and November 2016 to zero.

<p>outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>			<p>Over the last 10 months up until July 2017 the number of UTIs per month have been below the industry average. The service has been successful in reducing UTIs.</p>
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End of the report.