

Fergusson 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 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:	Fergusson Home Limited
Premises audited:	Fergusson Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 July 2015 End date: 14 July 2015
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:	34

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

Fergusson Home is one of three facilities which is privately owned and operated by a family, trading as the Cantabria group. It provides rest home level care for up to 44 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management, one general practitioner (GP) and staff.

There were no areas for improvement to follow up from the previous audit.

Feedback from residents and family/whānau members was positive about the care and services provided.

There are no areas for improvement identified from this audit.

Consumer rights

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



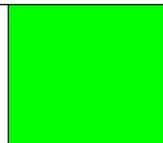
Standards applicable to this service fully attained.

Processes for open and honest communication are implemented. Residents and families are fully informed of any adverse events. The service can access interpreting services when this is required.

Fergusson Home implements policy and procedures to ensure all complaints are documented, reviewed, followed up and fully addressed. At the time of audit there is one open complaint.

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.

The Cantabria groups governing body ensure that business and strategic planning is in place, covering all aspects of service delivery and to show how services are planned and coordinated to meet residents' needs. Fergusson Home personalise aspects of the annual plan and report achievements to head office monthly to show how goals are being met. Service delivery is overseen by a nurse manager who is qualified for the role she undertakes.

The service has quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff and residents as appropriate.

The day to day operation of the facility is undertaken by staff who are appropriately experienced, educated and qualified. As confirmed during resident and family/whānau interviews residents' needs are met.

The service implements documented staffing levels to ensure contractual requirements are met.

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.		Standards applicable to this service fully attained.
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Care and interventions are provided within time frames that meet the residents' needs and contractual requirements. The documented care plans are based on the assessed physical, psycho-social, cultural and spiritual needs of each of the residents. The care is evaluated at least six monthly, to ensure the residents are responding to meeting their identified goals. When there are changes in needs, interventions are updated and carried out as required. Staff demonstrated knowledge in providing interventions and services for the residents.

Planned activities are based on the interests and strengths of the residents.

The food and nutritional services are provided to meet the needs of the older person living in a long term care environment.

Medicines are safely managed to meet legislation and best practice guidelines. Staff who assist in medicine management are assessed as competent to perform their role.

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.

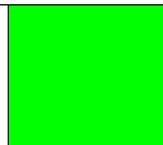


Standards applicable to this service fully attained.

The building has a current building warrant of fitness.

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.

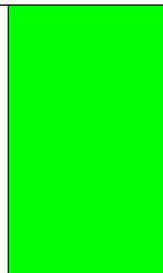


Standards applicable to this service fully attained.

There are no restraints or enablers in use at Fergusson Home at the time of audit. Policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Enablers are described as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education plan.

Infection prevention and control

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



Standards applicable to this service fully attained.

There is monthly surveillance of infections. This infection data is collated and analysed. When trends or an increase of infections are noted, actions are implemented to reduce the reoccurrence. The staff demonstrated sound infection prevention and control practices and knowledge.

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	16	0	0	0	0	0
Criteria	0	39	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Complaints management is implemented to meet policy requirements. Fergusson Home has a complaints register which identifies the issue, the dates received, dates reviewed and date closed off. Complaints follow-up is documented and complaints are closed off by the nurse manager accordingly. All complaints are reported to head office. At the time of audit there is one complaint outstanding. This complaint was made by the local needs assessment service and a full review has been completed by the nurse manager. Information has been sent to the complainant and the service is awaiting a response. The complaint has been open since April 2015.</p> <p>The nurse manager confirmed complaints management information is used as an opportunity to improve services as required. Management, resident and family/whānau interviews, confirmed that complaints management was explained during the admission process. Staff verbalised their understanding of the complaints procedures and confirmed that they implemented the complaints process for written and verbal complaints that occur. Complaints are a standing agenda item for staff meetings.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>All current residents speak English as their first language. The service has processes for accessing interpreter services when needed. All residents and families report that effective communication is provided by management and staff.</p> <p>The residents and families report they are kept fully informed. The incidents and accident forms record that the resident, and where applicable, the family/next of kin, are informed of any injuries or accidents. Staff demonstrated knowledge of the resident's right to full information and open disclosure.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business and quality plan for Fergusson Home was updated in April 2015. The organisation's goals, philosophy and mission statement are clearly identified and underpin the direction of the organisation. Each goal is reviewed and reported against monthly at senior management level.</p> <p>On the day of audit there were 34 rest home level care residents at the facility.</p> <p>The nurse manager is a registered nurse and has been in her role for four years. She maintains her education to a level required for the role she undertakes. The nurse manager's job description identifies her authority, accountability and responsibility for the provision of services. The organisation's group manager represented the organisation on the day of audit.</p> <p>Interviews with residents and one family/whānau member confirmed that their needs were met by the service.</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>The quality and risk management system documented is understood and implemented by service providers. This includes the development and update of policies and procedures at organisational level which identify interRAI requirements, regular internal audits, incident and accident reporting with detailed falls data, adverse events, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed.</p> <p>All reporting is linked to management processes via an electronic system. The monthly facility data is monitored by head office. Results are used at facility level to inform ongoing planning of services to ensure residents' needs are met.</p>

		<p>Corrective actions sighted are well documented and signed off by the nurse manager following implementation and evaluation processes. One example related to the acquisition of non-slip flooring being put in the resident bathroom areas.</p> <p>Actual and potential risks are identified and documented in a very detailed manner in the hazard register. Newly identified hazards are documented and discussed at staff meetings and if they cannot be eliminated they are escalated to the senior management focus group. Hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Resident and family/whānau interviews confirmed they are happy with the services provided. Staff are able to verbalise quality improvements and how they have been embedded into everyday practice, such as the correct use of personal protective clothing related to infection control.</p>
<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>	<p>FA</p>	<p>Policy is implemented related to accidents, incidents and near misses which are recorded and reported to management accurately, in a timely manner. Staff interviewed stated they report and record all incidents and accidents. Incident and accident information identifies corrective actions required.</p> <p>Documentation confirms that information gathered from incident and accidents is used as an opportunity to improve services where indicated. One example relates to a resident who tended to wander and a GPS tracking bracelet has been obtained with family/whānau permission. Data collected is benchmarked against the groups other facilities and comparisons are made against previously collected data from Fergusson Home. This data identifies that the fall rate has remained unchanged, with minor monthly fluctuations, over the past 12 months.</p> <p>Falls are reviewed at each staff meeting and information is collated to identify if any injuries were sustained or if there are any common trends. All events are fully investigated and reviewed to ensure corrective actions required are in place to assist a positive outcome. Processes, such as the use of sensor mats, hip protectors and increased frequency of observation are put in place for 'frequent fallers'.</p> <p>The nurse manager and the organisational operations manager fully understood the obligations in relation to essential notification.</p> <p>One family/whānau member interviewed confirmed they are kept well informed of</p>

		any concerns the staff may have or of any adverse events related to their relative. This is supported during a review of resident incident and accident forms and resident file reviews.
<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>Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation. Upon employment, referees are checked and job descriptions clearly describe staff responsibilities and accountabilities. Staff have completed an orientation programme with specific competencies for their roles, which are repeated annually, as confirmed during staff files reviewed. Staff annual appraisals are up to date.</p> <p>Staff undertake training and education related to their appointed roles. A recent quality improvement has resulted in regular toolbox education sessions being presented at each staff meeting in addition to regular specific training days as identified on the annual education calendar. The education calendar is set at organisational level. Staff attend education at another group facility which includes having guest speakers. Staff have the opportunity to attend off-site seminars and training days to ensure all aspects of service provision are met. This was confirmed in the education records sighted in staff files.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. Caregivers are encouraged to undertake an aged care qualification.</p> <p>Residents and one family/whānau member interviewed identified that residents' needs are met by the service.</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>	FA	<p>Organisational policy identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe quality care. Staffing requirements are monitored at head office to ensure staffing numbers match residents' level of care needs according to safe staffing guidelines.</p> <p>A review of four weeks rosters show that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that residents' needs are met. This is supported by resident interviews.</p> <p>There is at least one registered nurse on duty for eight hours Monday to Friday and</p>

		<p>an enrolled nurse Saturday and Sunday. A registered nurse is on call at all times. All shifts are covered by a staff member who holds a current first aid certificate.</p> <p>There are dedicated activities, kitchen, and cleaning staff. Laundry is undertaken as part of the care assistance daily duties.</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>	FA	<p>Medicines are delivered from the pharmacy in pre-packed dispensing systems. A safe medicine management system that complies with legislation and aged care safe practice guidelines was observed. Medications and controlled drugs are securely stored. There are no standing orders. All medications are individually prescribed and dispensed in the pre-packed system. Each medicine prescription and medication record has the required information and detail to comply with legislation. Medication reviews have been documented at least three monthly on the medication charts.</p> <p>Residents who self-administer their medications have a monthly competency review and assessment. Staff demonstrated competency with medicine administration at the time of audit.</p> <p>All staff who assist with medication management are assessed as competent to do so; these are conducted annually. When there has been medication errors, interventions and corrective actions are implemented to ensure staff have continued competence to administer medications.</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>	FA	<p>The five week rotational menu, with seasonal variations, was last reviewed in June 2014 by the organisation. The dietitian review of the menu was last conducted in 2013. The menu is suitable for the older person living in long term care. Residents are routinely weighed monthly (or more frequently if there are any concerns with unexpected weight loss). The kitchen service receives the nutritional profile for each resident. Residents with additional needs or special diets have this recorded on the white board in the kitchen. Nutritional supplements are given as indicated to meet individual resident's needs. Specific interventions for unexpected weight loss was implemented in one of the files reviewed, with the resident's subsequent weight gained recorded. Residents are asked each day what meal option they would like. The residents reported satisfaction with the meals and fluids provided.</p> <p>All aspects of the kitchen services meet current legislation. All kitchen staff have</p>

		food safety training. The observed preparation, serving and storage of meals complies with food safe guidelines.
<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	The care plans clearly described the interventions and services to meet the residents' needs. The service has implemented the required electronic interRAI assessment for all residents. The service use the interRAI and other relevant assessment tools to create the care plan. The care plan format includes interventions for the resident's assessed physical, psycho-social, cultural and spiritual needs. Staff demonstrated knowledge of the interventions required for each resident. The residents and family member reported satisfaction with the care and interventions provided.
<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	The residents were observed to be participating in meaningful activities. There are planned activities five days a week, with volunteers and staff assisting with activities on the weekends. The activities coordinator, who has been at the service for three weeks, reports that they are currently seeking feedback from residents during activities to ensure the current programme is meaningful to the residents. The activities coordinator has incorporated this feedback to make some amendments to the activities plan. The activities coordinator reported the activities are modified according to the capability and cognitive abilities of the resident, with examples given of how activities have been modified for residents with sight impairment. The activities programme covered physical, social, recreational and emotional needs of the residents. There was diversional therapy, activities, social and cultural assessments sighted in the residents' files reviewed.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Evaluations are recorded on the care plan. The evaluation of care describes how the resident is progressing towards meeting their goals. Where progress is different from expected the service uses a short term care plan to identify and record these temporary needs. If the change is ongoing, this is recorded and updated on the long term care plan. Short term care plans were sighted in the files reviewed.
Standard 1.4.2: Facility Specifications	FA	Documentation identifies all processes are maintained for the facility's current

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>building warrant of fitness which expires on 12 October 2015. There have been no changes made to the footprint since the previous audit.</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>There is monthly surveillance of infections. The service used standardised definitions appropriate to aged care when determining an infection. All results are analysed and trended by the infection control coordinator. Data is discussed at the health and safety and infection control group meetings. Each infection event is linked to age and sex demographics as well as any other risk factors.</p> <p>The infection surveillance data sighted recorded an increase in urinary tract infections for March 2015. The infection control coordinator analysed the possible cause and actions were implemented to reduce the infections. Staff meetings record the actions implemented. The number of urinary tract infections was reduced in subsequent months. The staff demonstrated knowledge of infection prevention and control and strategies to reduce urinary tract infections.</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 minimisation policy identifies that the use of enablers are voluntary and the least restrictive option to meet the needs of the resident.</p> <p>Fergusson Home have no enablers or restraints in use at the time of audit. Staff confirmed during interview they understand the requirements for both restraint and enablers.</p> <p>Staff education is undertaken as part of the orientation and annually thereafter to ensure staff knowledge is up to date should restraint be put in place.</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, 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.