

# Clair House Limited

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## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Clair House Limited
<b>Premises audited:</b>	Claire House Aged Care Facility
<b>Services audited:</b>	Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 23 November 2015    End date: 23 November 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	53

# Executive summary of the audit

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## 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 provides rest home and physical disability level care for up to 54 residents and on the day of the audit, there were 53 residents. Two registered nurses support the owner/manager. The residents interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of 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, the manager/owner, staff and a general practitioner. No relatives were available for interview.

The service has addressed one of one shortfall from the previous certification audit around medication management. The service has maintained continuous improvement around the quality and risk management programme.

This surveillance audit identified that an improvement is required around business planning.

## 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.
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There is evidence that residents and family are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The quality process being implemented includes an internal audit programme, monitoring adverse events and a health and safety programme that includes hazard management. Quality and risk information is reported at staff meetings. Residents and family are provided with the opportunity to feedback on any issues that arise.

Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. An education and training programme is in place for staff. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing. Healthcare assistants and residents report staffing levels are sufficient to meet residents' needs. Two registered nurses are employed Monday - Friday. A registered nurse is on call when not available onsite. There are adequate numbers of staff on duty to ensure residents are safe.

## 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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The registered nurses are responsible for each stage of service provision. The assessments, care plans, interventions and evaluations are completed within the required timeframes. Residents interviewed confirmed they participate in the care planning process. The general practitioner reviews residents at least three monthly. There is evidence of allied health professional input into the care of residents as required.

The activity programme is varied and appropriate to the level of abilities of the residents in the rest home. Community links are maintained. Entertainment and outings are provided.

Medications are managed, stored, and administered in line with medication requirements. All staff responsible for administering medicines complete medication training and competencies. Medication charts evidence three monthly reviews.

Food is prepared on site. Individual food preferences and dietary requirements are documented. Alternative choices are offered for dislikes.

## 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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A current building warrant of fitness is posted in a visible location.

## 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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A restraint policy includes comprehensive restraint procedures. There documented definitions of restraints and enablers align with the definitions in the standard. There are currently no residents requiring enablers or restraints. Staff receive training on restraint minimisation and managing challenging behaviours.

## 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.
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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. The infection control coordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. The service engages in benchmarking with similar facilities through Healthcare Help.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	1	37	0	1	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available and used by the residents. Information about complaints is provided on admission. Interviews with residents confirmed their understanding of the complaints process. They confirmed that the manager/owner is approachable. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register is held in hard copy and electronic formats. All complaints lodged in 2015 were minor and were resolved with evidence of an investigation and action(s) taken for each complaint received. The complaints process is linked to the quality and risk management programme.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Ten accident/incident forms were reviewed with evidence of open disclosure documented. Family are kept informed of any accident/incident unless the resident has consented otherwise. Interviews with the RN confirmed family are notified following changes in health status. No family were available during the audit.</p> <p>Monthly residents meetings provide a forum for residents to discuss issues or concerns on every aspect of the service. Access to interpreter services are available if needed although have not been required.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised</p>



		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</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Low	<p>Claire House Limited 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. On the day of audit there were 51 rest home residents and two residents under the YPD contract.</p> <p>The business plan reviewed does not comprehensively cover all aspects of the service provided. The key areas of focus have been reviewed.</p> <p>The manager/owner has owned the facility for 30 years. She has maintained at least eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management programme is in place. Quality goals are listed in the CQI meeting minutes (link to finding 1.2.1.1). 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.</p> <p>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.</p> <p>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.</p> <p>Falls prevention strategies are in place that include the identification of interventions to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Ten accident/incident reports selected for review reflected immediate actions with follow-up action(s) taken by a registered nurse.</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>The service collects monthly data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Numbers of accidents and incidents in 2015 are very low with trends of 'fall-free' days identified. Monthly meeting minutes, staff handover and the communication book evidences discussions around incidents and accidents.</p> <p>Discussions with the manager/owner and one registered nurse (RN), confirmed their awareness of statutory requirements in relation to essential notification. 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>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The RNs practising certificates are current. All five staff files randomly selected for review had relevant documentation relating to employment. Annual performance appraisals were completed.</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.</p> <p>There is an annual education plan being implemented that includes monthly competencies that must be completed by staff. One of two RNs have completed their InterRAI training.</p> <p>There is a minimum of one care staff with a current first aid certificate on every shift.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the manager/owner who works full-time and lives on the premises, two part-time RNs are employed Monday – Friday. An RN is on-call when not on-site. Healthcare assistants assist the designated laundry staff. Cleaning staff are employed over seven days a week. An activities coordinator is rostered Monday – Friday with an activities assistant working one day (four hours) on the weekends.</p> <p>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>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All health care assistants responsible for the administration of medications complete an annual medication competency and attend medication education. All medications are checked on delivery against the medication charts by the registered nurses. Standing orders meet the current</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>requirements. There are policies and procedures in place for self-medication. Only one resident currently self-medicates and the resident and GP have signed a consent form. Competency is checked daily and three monthly.</p> <p>The 10 medication charts sampled had photo identification and allergy status noted. The GP had reviewed the medication charts at least three monthly. Medication administration signing sheets reviewed were completed appropriately. The previous finding has now been addressed. Medications are stored and administered in line with accepted guidelines and legislation.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Clair House are prepared and cooked on-site. There is a six weekly seasonal menu, which has been reviewed by a dietitian. Meals are served from bain maries in each dining room.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at meal times. Care staff provide assistance to those residents who require it.</p> <p>Resident meetings allow the opportunity for resident feedback on the meals and food services. Residents interviewed were complimentary of the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food temperatures are recorded for each meal. Chemicals are stored safely. Staff were observed to be wearing correct personal protective clothing.</p> <p>All food services staff have completed food safety and hygiene, and chemical safety training.</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>A written record of each resident's progress was documented as evidenced in the residents' files reviewed. When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The care staff stated they have all the equipment (referred to in care plans) necessary to provide care. The residents stated their needs were being met.</p> <p>Dressing supplies are available. Wound initial assessment plans and wound evaluations were completed for one surgical wound where the donor site became infected, one category one skin tear and one rash. All wounds have been evaluated within the required timeframes. Short-term care plans were in place for all wounds. There are pressure area prevention resources available, however, there are currently no pressure injuries. There is wound care specialist advice available as needed.</p>

		Continence products are available and specialist continence advice is available as needed.
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an activity coordinator for 27 hours per week, and an activity assistant for four hours per week (at the weekend). The activities staff attends diversional therapy meetings and workshops. There are adequate resources available. The programme is flexible and includes exercises to music, crafts, shopping, games, quizzes, bingo, musical entertainment and outings. There is a happy hour monthly. The activities staff visits residents in their rooms for one on one if they do not wish to join in. Special occasions such as birthdays, Mother's Day, Anzac Day and Easter are celebrated. The facility is currently decorated for Christmas.</p> <p>A priest visits weekly and there is a monthly (non-denomination) church service.</p> <p>Activity assessments are completed on admission in the residents' files sampled. Activity plans and care plans are reviewed at the same time. There are monthly residents' meetings that allow for feedback on the activity programme.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In the care plans sampled, all were reviewed and evaluated by the registered nurses at least six monthly, or as necessary. Residents stated that they are involved in the evaluation of the care plan. There is documented evidence of family involvement. The GP examines the residents and reviews their medications three monthly or as necessary. Short-term care plans for short-term needs (sighted) were evaluated within a timely manner.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current building warrant of fitness which expires 21 January 2016.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	FA	<p>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). Benchmarking occurs</p>

<p>and methods that have been specified in the infection control programme.</p>		<p>against similar facilities through Healthcare Help. Infection rates have been low. The GP reviews antibiotic use at least three monthly with the medication review. There have been no outbreaks. 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>There are policies around restraints and enablers including definitions. The manager/owner is the restraint coordinator and is knowledgeable regarding this role. During the audit there were no residents using a restraint or an enabler. Enablers are voluntary. Staff receive annual training around restraint minimisation and managing challenging behaviours by an external consultant.</p>

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	The business plan has broad headings documented that define the intent of the plan with evidence of annual reviews for a period of three years.	The business plan includes an intent, but is missing a purpose, values, scope, direction and measurable goals. Quality goals were documented in the continuous quality improvement (CQI) meeting minutes but were not linked to this business plan. There was evidence of the annual review of the business plan	<p>Ensure the business plan includes a purpose, scope, direction and measurable goals, is linked to the quality management programme, and is regularly reviewed.</p> <p>90 days</p>

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

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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 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	Robust quality and risk management systems are being implemented by the service.	The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. A quality improvement register 2015 is maintained and lists the key objectives, interventions and evaluations of the improvements listed. Claire House has also been part of the Auckland DHB 'first do no harm' project. Wander track GPS trackers are available for residents who are at risk of wandering. The service takes opportunities to be involved with initiatives led by Auckland DHB and has implemented the 'do no harm' project to reduce falls with evidence of falls reduction. They are involved in the 'Stop and Watch' early warning tool that provides guidelines around assessment of a resident with changes in state/behaviour. Falls risk assessments are in place. A physiotherapist is available 'as needed', which the owner/manager reports is as frequent as weekly. The healthcare assistants state they are fully informed and involved in the quality programme and in the falls prevention initiatives. The outcome of the falls prevention quality initiative has evidenced a downward trend in the number of falls.

End of the report.