# New Vista Rest Home Limited

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** New Vista Rest Home Limited

**Premises audited:** New Vista Resthome & Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 26 November 2015 End date: 26 November 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:** 52

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

New Vista Rest Home and Hospital provides rest home and hospital level care for up to 52 residents. Forty of the beds have been approved as dual purpose beds that are able to be used for hospital or rest home level care. The residents and families reported they are positive about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service’s contract with the District Health Board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There is one area requiring improvement relating to aspects of the food service.

## Consumer rights

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

Staff demonstrate an understanding of residents' rights and obligations. Information regarding residents’ rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The complaints register is current and all complaints have been entered. There have been no investigations by external agencies since the last certification audit.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

New Vista Rest Home Limited is the governing body and is responsible for the services provided at this facility. A business plan and a quality and risk management plan were reviewed. The facility manager provides a two monthly comprehensive written report to the governing body.

The facility is managed by a facility manager who is an enrolled nurse and has been in this role since 2012. The facility manager is supported by a clinical manager and a quality manager. The clinical manager is responsible for the oversight of clinical services in the facility.

Clinical indicators are reported to the governing body by the quality manager. There is an internal audit programme and audits are completed. Risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, infection control surveillance, accident/incident forms, meeting minutes and surveys evidence comprehensive analysis of data and corrective action plans are developed to address any issue/s that require improvement.

Numbers of various clinical indicators and quality and risk issues are reported via the quality and staff meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management. Staff files evidenced job descriptions, orientation, performance appraisals, and police vetting. Current practising certificates are held on files for all health professionals who require them to practice.

An in-service education programme is provided for staff monthly. Caregivers are also required to complete the New Zealand Qualifications Authority Unit Standards. All clinical staff have current competencies relating to restraint and staff who are responsible for medicine management.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager and clinical manager are rostered on call after hours. Care staff interviewed reported there is adequate staff available.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

Residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals. Some aspects of food preparation and storage are identified as areas requiring improvement.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

A current building warrant of fitness is displayed.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Documentation of policies and procedures and interview of the facility manager demonstrated residents are experiencing services that are the least restrictive. The number of residents using restraint has decreased since the previous audit.

## Infection prevention and control

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

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

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The quality manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The complaints register is current and evidenced six written and verbal complaints received for 2015. Documentation showed all complaints have been investigated and complainants provided with responses in a timely manner and that the complainants were satisfied with the outcome of the complaint.The quality manager advised there have been no investigations by the Ministry of Health, DHB, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit. Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Systems are in place that ensures residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident survey for 2015 evidenced residents knew the process for making a complaint.The complaint process and forms were observed to be readily accessible and displayed. Quality and staff meeting minutes evidenced reporting of any complaints as an agenda item. Care staff confirmed information was reported to them via their staff meetings. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members is recorded in the resident’s file. Family members expressed satisfaction with how well they were kept informed about any change to the resident’s condition and their involvement in resident care planning. Residents’ meetings are held two monthly and minutes were reviewed. The facility manager advised that interpreters are able to be accessed from the interpreter services or family members if required. This information is also provided to residents/families as part of the information/admission pack.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | New Vista Rest Home Limited is the governing body and is responsible for the services provided at this facility. A business plan was reviewed that includes a mission, values statement, vision, purpose, intent, strengths, goals and opportunities. A quality plan was also reviewed. The facility manager who is an enrolled nurse (EN) has been in their current position since 2012. The management of clinical services is the responsibility of the clinical manager who has been in their role since July 2015. Prior to this they were employed as a RN in this facility. The annual practising certificates for the facility manager and clinical manager are current. There was evidence on the facility manager’s and clinical manager’s files of ongoing education.The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service. New Vista Rest Home and Hospital occupancy during this audit was 22 rest home residents and 29 hospital residents including one resident under the age of 65 years. The service provider has funding contracts with the district health board (DHB) to provide aged related residential care, long term support – chronic health conditions – residential, intermediate care services and carer relief, a dedicated respite bed. A contract with the Ministry of Health is also held for residential - non aged. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk plan is used to guide the quality programme and includes goals and objectives. An internal audit programme is in place and internal audits completed in 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures.Monthly quality meetings include RNs, ENs, health and safety, restraint and infection prevention and control. Staff meetings are held quarterly, with a comprehensive newsletter provided to staff monthly. Resident meetings include an education session. Meeting minutes including quality data are available for review by staff. Meeting minutes and staff newsletters reviewed evidenced reporting / feedback of completed internal audits, quality data, including clinical indicators which are graphed. The quality manager is responsible for ensuring the organisations quality and risk management systems are maintained. Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data includes: adverse event forms; internal audits and meeting minutes and evidenced corrective action plans are being developed, implemented, monitored and signed off as being completed. Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for the service delivery.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Staff document adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the quality manager and signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The registered nurses undertake assessments of residents following an accident. The registered nurses complete neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting, for example: health and safety; human resources; infection control. The facility manager reported they have not had any events to report concerning essential notifications. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, and police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.The facility manager is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided and staff attendance is high. Competency assessment questionnaires are current for medication management and restraint. The clinical manager and other RNs have the required interRAI assessments training and competencies.All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week. On call after hours is provided by the facility manager and the clinical manager. The minimum number of staff on duty is during the night and consists of a registered nurse (RN) and two caregivers. Staff interviewed reported there is adequate staff available and that they are able to get through their work. All RNs, ENs, and the diversional therapist have a current first aid certificate. Residents interviewed reported staff provide them with adequate care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is comprehensive and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Controlled drugs are stored in separate locked cupboards. Controlled drugs, are checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly and six monthly stock checks and accurate records.The records of temperature for the medicine fridge had readings documenting temperatures within the recommended range. The GP’s signature and date was recorded on the commencement and discontinuation of medicines. The three monthly medication review was recorded on the medicine charts. Residents’ who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Standing orders are used when each resident has their use approved by their GP. Standing orders documentation is compliant with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s assessment of the planned menu in June 2015. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is sighted. Some aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines, however some aspects require attention.A cleaning schedule was sighted, however this is not supported with documentation to verify compliance. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents’ needs and desired outcomes and best practice guidelines. Residents and family/whanau members expressed satisfaction with the care provided. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Meeting minutes and satisfaction surveys evidenced the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN. Formal care plan evaluations, following reassessment, using the interRAI assessment tool to measure the degree of a resident’s response in relation to desired outcomes and goals, occur every six months or as residents’ needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A short term care plan is initiated for short term concerns. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed that expires on the 22 June 2016.The facility manager advised the remaining wing of the facility that has not yet been upgraded will have building work done in the new year and this will include extending the wing.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. These are collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality meetings and any ongoing corrective actions discussed and presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. Any immediate action required is presented to staff at hand over. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The definition of restraint and enabler is congruent with the relevant standard. There were six residents using restraint and four using enablers. The facility manager advised the use of restraint has decreased by seven since the last audit. This has been achieved by using sensor mats, high/low beds and monitoring residents very closely. Review of the restraint register confirmed the reduction in the use of restraint. Staff were able to describe the process should restraint be required.  |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Documentation sighted evidenced some aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines, however some aspects of food preparation and storage require attention. Shelves in the pantry have chips in the Formica, exposing bare wood. The freezer is full with supplies, some not dated. Goods decanted into some containers are not dated. Ice build-up is evident on the freezer walls and amongst the food items. No evidence of cleaning or defrosting was sighted. Documentation was unable to verify compliance with the cleaning schedule.  | Some aspects of food preparation and storage do not comply with current legislation and guidelines. | Provide evidence all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.180 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.