Cunliffe House Retirement Home 2006 Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Cunliffe House Retirement Home 2006 Limited
Premises audited:	Cunliffe House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 December 2015 End date: 17 December 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: 20

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
	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

Cunliffe House rest home is certified to provide rest home level care for up to 23 residents. On the day of the audit, there were 20 residents. This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff and management.

The owners/managers have owned the facility for nine years and supported by a trainee manager and two registered nurses. All are appropriately qualified and experienced. Feedback from residents and relatives is positive.

The previous audit did not identify any shortfalls.

This audit has identified areas requiring improvement around policies around InterRAI, incident and accident analysis and meeting minutes, the hazard register, timeliness of documentation, care plan interventions, review of activities plans and medication documentation.

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.

Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family reported they are well informed including any changes in resident's health. The owner/managers have an open door policy.

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 medium or high risk and/or unattained and of low risk.

Cunliffe House has a documented quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Incidents are documented and there is immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

The building holds a current 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.

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There are no restraints or enablers being used. Staff are trained in restraint minimisation and challenging behaviour management.

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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	10	0	3	3	0	0
Criteria	0	31	0	6	2	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Four complaints have been received in 2015 to date and review of these showed appropriate processes and adherence to timeframes. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Residents (five) and family (two) interviewed, stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and given time and explanation about services and procedures. Incident forms and corresponding resident files reflect that family are informed of incidents. Resident/relative meetings occur monthly and the facility manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Cunliffe House rest home provides care for up to 23 residents at rest home level care. On the day of the audit, there were 20 residents (all under the Aged Residential Care contract). The owners/managers have owned the facility for nine years. A trainee manager and two part time registered nurses support them. The owners/managers and the trainee manager attend regular conferences and training to meet education requirements. The 2015 business plan documents the mission and philosophy of the organisation. The quality plan includes annual goals and review of the previous year's goals.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	Meeting minutes have been maintained for monthly staff meetings and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including two caregivers and two registered nurses) confirmed their involvement in the quality programme. Resident/relative meetings have been held monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use (of which there is none). Infection data is analysed but this has not consistently occurred for accident/incident data. The internal audit schedule for 2015 has been completed. Areas of non-compliance identified at audits have been actioned for improvement. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The hazard register is overdue for review. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The death/Tangihanga policy and procedure outlines immediate action to be taken upon a resident's death. Policies have not been updated to include InterRAI requirements. Falls prevention strategies are implemented for individual residents. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically	FA	Incident and accident data has been collected. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of 12 resident related incident reports was reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Monthly and six monthly reviews of incidents inform quality initiatives.

recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		
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.	PA Low	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (the activities coordinator, the cook, a registered nurse and two caregivers) and included all appropriate documentation except job descriptions and reference checks. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. The completed in-service calendar for 2015 exceeded eight hours annually and covered appropriate topics. The registered nurses and caregivers attend external training including seminars and education sessions with the local DHB.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Cunliffe House has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse on duty or on call at all times. There is a registered nurse on site five days per week. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift. There is at least one staff member trained in first aid and CPR on duty at all times.
Standard 1.3.12: Medicine Management Consumers receive	PA Moderate	The service uses individualised blister packs that are checked-in on delivery by two staff. A caregiver was observed administering medications correctly. Medications and associated documentation were stored safely and securely. Weekly controlled drug stocktakes had not always occurred. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 10 medication

medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		charts reviewed. An annual medication administration competency is completed for all staff administrating medications and medication training had been conducted. There is a self-medicating residents' policy and procedures in place. No residents self-administered medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Medication administration records sampled documented all prescribed medication being administered. Not all medication charts reviewed recorded accurate indications for use of 'as required' medication by the GP.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at the service are prepared and cooked on site. There is a four weekly winter and summer menu, which has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen and served to the residents in the adjoining dining room. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures. Staff were observed serving and assisting residents with their lunchtime meals and drinks. Diets are modified as required. Food services staff know resident dietary profiles, and likes and dislikes and any changes are communicated to the kitchen via the registered nurses. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	All care plans sampled are current, however not all had interventions recorded to reflect the assessments conducted and the identified requirements of the residents. Interviews with staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room was stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Appropriate wound documentation was completed for the one resident with a minor skin tear.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	The activities coordinator works 20 hours per week over five days and as required, providing an activities programme with support from external providers and other staff. The activities coordinator was not at work on the audit day. The programme is planned monthly. Activities planned for the day are displayed on notice boards around the facility. An activity plan is developed for each individual resident based on assessed needs as part of the care plan. Two of four activity plans were reviewed six monthly but the documented review only consists of a date (link 1.3.8.1). Residents are encouraged to join in activities that are appropriate and meaningful and are

requirements are appropriate to their needs, age, culture, and the setting of the service.		encouraged to participate in community activities. There are regular outings. Residents were observed participating in activities on the day of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Care plans are evaluated within the required timeframes. Activities care plans were not all reviewed six monthly and reviews completed only included a date.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness.
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.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Monthly registers of types of infection are developed and analysis with results has not always been provided to staff at the staff meetings (link 1.2.3.6).

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with staff. There are no residents requiring restraint and no residents using enablers. There is a documented definition of restraint and enablers in the policies, which is congruent with the definition in NZS 8134.0. Staff have had training around restraint minimisation and the management of challenging behaviours.

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 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Low	The service has a comprehensive suite of policies that reflect good practice. The policies are reviewed regularly; however, policies have not been updated to reflect InterRAI requirements.	Policies have not been updated to include InterRAI requirements.	Ensure policies are updated to reflect InterRAI requirements. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Accident and incident data is collected on a monthly summary sheet. The back of the sheet includes a template for analysis of incidents. This has not been consistently completed.	(i) Accident/incident data is not consistently analysed for	(i) Ensure all quality data is analysed for trends.

			trends.	90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	There is a hazard register that documents identified hazards and risk management strategies. Staff interviewed reflect hazards are minimised and promptly addressed. The hazard registered was last reviewed in 2013.	The hazard register has not been reviewed since 2013.	Ensure the hazard register is reviewed regularly. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Five of five staff files sampled included interview documentation, qualification and ongoing appraisals. Reference check documentation was missing.	Five of five staff files sampled did not contain a reference check.	Ensure that reference checks are completed and documented for all new staff. 90 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	All 10 medication charts sampled documented that all medications are prescribed by a GP and reviewed at least three monthly. All had a photograph and allergies identified. Seven of ten charts had indications for use documented for 'as required' medications. Two staff check controlled drugs at the	(i) Three of ten medication charts sampled did not document the indication for use	(i) Ensure all 'as required' medications prescribed document the indication for

		time of administration. Weekly checks have not consistently occurred.	for 'as required' medications. (ii) Weekly controlled drug checks have not always occurred.	use. (ii) Ensure that weekly controlled drug stocktakes are completed. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The registered nurses interviewed reported they were aware of the required timeframes from the aged residential care contract around assessments and medical reviews. They reported that the GP does not like to admit resident's prior to receiving old notes. Not all residents were seen within two working days of admission. Three of five files sampled had evidence of the resident being reviewed by the GP at three monthly intervals or more often if need dictated. One resident had not been at the service for three months. Two of five resident files sampled demonstrated that an initial assessment and care plan were completed on the day of admission.	(i) Two of five resident files sampled did not have the initial assessment completed within 24 hours of admission. A third had no date on the initial assessment and care plan. (ii) Two of five resident files sampled were not reviewed by the GP within two working days of admission. (iii) One of five resident files sampled had not been reviewed by the GP three	(i) Ensure all residents have an initial assessment completed within 24 hours of admission and that the date these are completed is recorded. (ii) Ensure all residents are seen by the GP within two working days of admission. (iii) Ensure residents are reviewed by the GP at least three

			monthly.	monthly. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	The caregivers interviewed are very familiar with the needs and care of residents and a strong verbal culture witnessed. There is evidence of referral to appropriate services when need dictated and regular review of residents by the registered nurses. Two of the four long-term care plans sampled (one resident was new to the service) documented interventions for all identified areas of need.	Two of five resident files sampled did not document interventions for all identified areas of need (management of blood glucose levels for diabetics, epilepsy and mental health issues).	Ensure all care plans document interventions for all identified areas of need. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Four of five resident files sampled had a comprehensive social and lifestyle assessment and an activities care plan that documented interests and goals. The fifth resident was new to the service and these documents were partially completed. Two of the four activities care plans that were completed had a date to evidence six monthly reviews. Progress towards goals was not documented.	Two of four activities plans sampled had not been evaluated six monthly and the two that had been evaluated six monthly did not document progress toward goals.	Ensure activities plans are reviewed six monthly at the time of the care plan review and that reviews document progress toward goals. 90 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.