Archer Care Facility Limited - Archer Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Archer Care Facility Limited

Premises audited: Archer Village

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 4 July 2016   End date: 5 July 2016

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

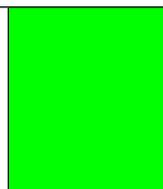| Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of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

General overview of the audit

Archer Care is part of the Archer Retirement Village and is certified to provide rest home level care for up to 55 residents. On the day of audit there were 52 residents. The care centre is managed by a site/quality manager with support from a clinical nurse manager. A general manager oversees the operations of the retirement village and care centre. Archer Village is governed by a charitable trust. The service continues to implement the Eden principles of care and provides pastoral care within the special character of the home.

This certification audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The audit has identified that improvements are required around risk management, essential notifications, registered nurse follow up of residents with clinical issues, assessments, care planning, interventions and warfarin management.

Consumer rights

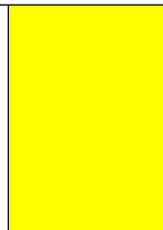|		
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural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

The staff at Archer Village strive to ensure that care is provided in a way that focuses on the individual and residents' autonomy is valued. Information about the Code of Rights and services is easily accessible to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed.

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.

The management role is being provided by a non-clinical site/quality manager with support from a clinical nurse manager, a general manager and care staff. Quality activities are conducted to identify improvements in practice and service delivery. Health and safety policies are implemented to manage risk. Staff advised that there is an orientation programme that provides new staff with relevant information for safe work practice. A roster provides sufficient shifts to cover for the delivery of care and support to rest home residents.

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 clinical nurse manager takes primary responsibility for managing entry to the service with assistance from the site manager. Comprehensive service information is available. The registered nurses complete care plans and evaluations within the required timeframes. All residents are assessed using the interRAI assessment tool. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored appropriately and the service has medication polices that comply with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. All bedrooms are single occupancy. Planned and reactive maintenance issues are addressed. Chemicals are stored safely throughout the facility.

There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Residents are being provided with safe and hygienic cleaning and laundry services, which are appropriate to the setting. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

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

There is a restraint policy that includes the provision of a non-restraint environment. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently no residents requiring restraints and no residents using enablers.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources

to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	38	0	2	5	0	0
Criteria	0	86	0	2	5	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (four home assistants, one diversional therapist, one enrolled nurse and the clinical nurse manager) confirm their familiarity with the Code. Interviews with nine residents and two relatives confirm the services being provided are in line with the Code. Code of Rights and advocacy training has been provided.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Eight resident files sampled demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Home assistants and the clinical nurse manager/registered nurse interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.
Standard 1.1.11: Advocacy And	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. The residents' files include information on residents' family/whānau and chosen social networks. Residents are provided with a copy of the Code and Nationwide Health and Disability Advocacy services pamphlets on entry. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in care decisions of residents.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The resident information pack states that visiting can occur at any reasonable time. Interviews with residents and relatives confirm that visiting can occur at any time. Family and friends were seen visiting on the day of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Archer staff support ongoing access to the community and entertainers are invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Interviews with residents and relatives are familiar with the complaints procedure. Eight complaints received in 2016 were reviewed. The complaints register has been maintained. Each complaint reviewed has a follow-up plan documented including the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. Advised that resident meetings and resident forums provide the opportunity for residents to air any concerns or issues.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that includes the Code of Rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identify they are informed about the Code of Rights. The site manager provides an open-door policy for concerns or complaints. Resident meetings and resident forums have been held providing the opportunity to raise concerns in a group setting. Advocacy pamphlets, which include contact details, are included in the information pack. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has links with the Baptist Church and employs a part-time chaplain. Church services are held. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful. Residents' files include their cultural and/or spiritual values when identified by the resident and/or family (link 1.3.5.2). Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Staff receive education and training on abuse and neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a Māori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. Residents who identify as Māori have this recorded in their long-term care plan. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training has been provided for staff.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Family involvement is encouraged e.g. invitations to residents' meetings and facility functions. The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the provision of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues which are provided to staff on employment. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries, evidenced on interview with the care staff. Interviews with staff confirm their understanding of professional boundaries.

| Standard 1.1.8: Good Practice

Consumers receive services of an appropriate standard.	FA	The quality assurance and risk management policy is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and on-going in-service training. The 2015 resident and relative satisfaction survey reflects high levels of satisfaction with the care that is provided. The site/quality manager is responsible for coordinating the internal audit programme. Policies and procedures have been reviewed. These are available in hard copy. Staff meetings, quality assurance and resident's meetings have been held. The service received an aged advisor award 2015. Residents and relatives interviewed spoke very positively about the care and support provided by the home assistants and registered nurse. Staff had a sound understanding of principles of aged care and state that they are well supported by the registered nurses. There are implemented competencies for home assistants and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication

Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies are in place relating to open disclosure. Residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.
A sample of incident reports reviewed and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member's health status. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
The facility has an interpreter policy to guide staff in accessing interpreter services. |
| Standard 1.2.1: Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Archer Care is part of the Archer retirement village. The care centre provides rest home level care to up to 55 residents. On the day of audit there were 52 residents, including two respite residents. Permanent residents were all under the age related contract. Archer is governed by a charitable trust board. The general manager reports to the board on a monthly basis. The site/quality manager oversees the care centre and reports to the general manager. The site/quality manager has been with the service for nine years and the clinical nurse manager has been with the service for 20 years. The manager has completed more than eight hours of training in the last year relating to the management of a rest home.

The service has a current strategic plan, a business plan and a quality and risk management programme. An annual quality plan has been developed. Progress toward previous goals has been monitored and documented. |

| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the site/quality manager, the clinical nurse manager is in charge with support from general manager, care staff and another part-time registered nurse.
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 Low | The quality programme includes the service philosophy, general objectives and lists the quality activities. An annual quality plan for 2016 has been developed and is being implemented. An internal audit schedule is being completed for 2016. Corrective actions have been developed where compliance is less than expected. This is evidenced in the meeting minutes reviewed for staff, quality/health and safety/infection control and resident meetings. Quality meetings evidence discussion of quality activities. Resident meetings are held with follow up of issues and discussions are completed.

There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

A resident survey and a relative survey was last conducted in November 2015 with respondents advising that they are overall very satisfied with the care that residents receive. Issues identified in the survey have been addressed with corrective actions implemented.

The service collects information on resident incidents and accidents as well as staff incidents/accidents (link 1.2.4.3). The service has a health and safety management system and hazard registers are documented for each area of service. Not all areas of risk are fully documented. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. The service maintained their tertiary level WSMP rating in a recent audit in June 2016. There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are implemented. |
| Standard 1.2.4: Adverse Event | PA Low | There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the registered nurses (link 1.3.3.4). Analysis of incident trends is conducted by the site/quality manager. |

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.		There is a discussion of incidents/accidents at quality and staff meetings. A sample of incident/accident forms reviewed for May and June 2016 had been commenced by either the registered nurses or the home assistants. Progress notes reviewed for a sample of resident's evidence that incidents and accidents have been reported. Follow up by a registered nurse is evident in the entire sample of resident incident forms reviewed however; this has not been completed in a timely manner (link 1.3.3.4). An incident in April 2016 involved a missing resident. The resident had been reported missing to the police. This incident was not reported to the MOH via a section 31 notification.
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	There are human resources management policies in place which includes 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. The human resources policies also include orientation, staff training and development. Eight staff files were reviewed (two registered nurses, two enrolled nurses, three home assistants, and one cook) and evidence that reference checks are completed before employment is offered. All files reviewed evidenced signed job descriptions. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. Staff files reviewed had completed orientation documentation. Staff were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Discussion with the site manager and clinical nurse manager and records reviewed confirms that an in-service training programme has been provided. Annual training days are provided for staff to attend. The in-service calendar for 2016 is being implemented.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing policy includes staff rationale and skill mix. The site manager and the clinical nurse manager both work full time. Another registered nurse works eight hours per week. Two enrolled nurses are also employed. There is a minimum of two caregivers on duty at any one time and a registered nurse on call. There is at least one staff member on each duty with a first aid certificate. Residents and family interviewed confirmed that sufficient staff are rostered on to provide care and services to residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Electronic file entries identify the staff member making the entry and are timed

recorded, current, confidential, and accessible when required.		and dated. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts and progress notes are maintained electronically.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical nurse manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARRC contract.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.
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.	PA Moderate	Sixteen medication charts were reviewed. The medication management policies and procedures comply with medication legislation and guidelines. An electronic medication management system is in place for regular medication. Paper based charts were being used for the prescribing of Warfarin. Not all Warfarin had been prescribed correctly and not all Warfarin was being administered as prescribed. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboard. Registered nurses and home assistants administer medicines. All staff that administer medicines are competent and have received medication management training. Medication administration practice complied with the medication management policy for the medication round sighted. The facility uses a robotically packed medication management system for the packaging of all tablets. The enrolled nurse on duty reconciles the delivery and documents this. There was evidence of three monthly reviews by the GP. On the day of audit, five residents were self-administering their own medicines and the documentation was correctly recorded and a competency assessment completed. There were no standing orders in use.

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	There is a fully functional kitchen and all food is cooked on-site by the dedicated kitchen staff. There is a four weekly rotating seasonal menu, which has been reviewed in May 2016 by an external dietitian. The food service is HACCP certified annually. There is food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. Archer has moved to self-service via a buffet to enable residents to "choose" what they want to eat at each meal. The kitchen is able to meet the needs of residents who require special diets and the hospitality supervisor works closely with the RNs. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	Files sampled indicated that personal needs information is gathered during admission in consultation with the resident and their family/whānau where appropriate. The interRAI is the only clinical assessment tool in use. The interRAI assessment tool was used to develop the long-term care plan and to review the resident at least six monthly or when there was a change to a resident's level of care (link 1.3.5.2). InterRAI assessments were commenced, or have been completed for all residents. Not all files sampled evidenced the use of appropriate assessment tools to identify clinical risk on admission or with a change in health condition. Not all initial wound assessments had been fully documented.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused,	PA Moderate	The service was in the process of transitioning from their current electronic care plan to the interRAI long-term care plan template. The care plans reviewed did not always describe the support required to meet the resident's goals and identified care needs. The interRAI assessment information did not always

integrated, and promote continuity of service delivery.		inform the development of the resident's long-term care plan. Short-term care plans were not evidenced for all acute changes in health status. Activity plans were documented but did not always include the unique issues for each resident or detail how the resident goals would be met. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process.
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	Registered nurses (RNs) and home assistants (HA's) follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse, hospice nurse or wound specialist nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place. Not all wound documentation has been fully completed (link 1.3.4.2). On the day of audit there were seven residents with wounds. This includes one resident with two chronic wounds, two blisters, one lesion, one surgical wound and one area of broken skin. There were no pressure injuries. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with the clinical nurse manager, registered nurse, enrolled nurse and home assistants demonstrated an understanding of the individualised needs of residents. Care plans do not always demonstrate interventions to meet residents' assessed needs (link 1.3.5.2). There was evidence of blood sugar monitoring charts and weight monitoring in use. There was no evidence of regular and consistent monitoring of elimination needs by the registered nurses.
Standard 1.3.7: Planned Activities 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.	FA	The service has achieved the seven Eden principles. Twenty of sixty-three staff have been trained in the Eden philosophy of care. The programme meets the recreational needs of the rest home level care residents and reflects normal patterns of life. The programme is supported by a team of volunteers. At least 40 hours per week of the resident's recreational programme are resident or volunteer lead. The service employs two social and event coordinators who work 60 hours per week. The weekend programme is delivered by care staff and volunteers. There is a set activity programme that is resident-focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, dusting, tidying drawers and making own beds (if able). There is evidence that the residents have input into review of the wider programme (via Eden circles and resident meetings) and this feedback is considered in the development of the resident's activity

		programme. Residents interviewed expressed satisfaction with the program.
		An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files sampled did not always reflect the specific needs and interests of each resident (link 1.3.5.2). Relatives and residents interviewed advised that the activity program was interesting and the residents were encouraged to participate.
		In the files reviewed the recreational plans had been reviewed six monthly at the same time as the care plans were reviewed. Activity participation was noted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there was a change in health status. There was at least a three monthly review by the GP. Not all changes in health status were documented and followed up (link 1.3.5.2). Reassessments have been completed using interRAI LTCF for all residents who have had a significant change in health status. The RN completing the plan, signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled (link 1.3.5.2). Where progress is different from expected, the service does not always respond by initiating changes to the care plan (link 1.3.5.2)
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Archer Care is a purpose built, single storey rest home situated in Christchurch. There are 55 bed rooms including 40 with ensuites. There are 15 rooms in the Port Hills neighbourhood (wing) which share communal bathroom facilities. The building has a current building warrant of fitness. There is a maintenance person employed to address the reactive and planned maintenance programme. There are gardeners employed to manage the lawns and grounds. All medical and electrical equipment were recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Two vans owned and operated for outings have current registration and warrant of fitness certificates.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All rooms in Archer Care are single rooms. The facility is divided in to four accommodation wings – three wings have full ensuites in each room and one wing has communal toilet and shower facilities. Each room has adequate space to move about in with the use of mobility aids. There are appropriately placed handrails. Privacy curtains are in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Archer Care facility has two small sitting areas, one large main lounge and a large dining room. The service also has a communal recreation centre shared with retirement village residents with a café, auditorium, meeting room, gym and indoor swimming pool. The dining room seating plan allows for social interaction to take place. The large lounge area has appropriately placed seating where group activities and individual activities can take place. There are small seating areas along the corridors where residents may rest when walking or enjoy some quiet time. Nine residents interviewed stated they are happy with the communal areas and the environment was homely. There is adequate seating and space to allow both individual and group activities to occur.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are dedicated cleaning and laundry staff. They have access to a range of chemicals, cleaning and laundry equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. The service has an emergency generator for emergency power and short-term back up power for emergency lighting. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with	FA	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Archer Care has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. The clinical nurse manager is the designated infection control coordinator with support from all staff as the infection control team. Quality/health and safety/infection control meeting minutes are available for staff. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The clinical nurse manager is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type | FA | The service has infection control programme policies and procedures that reflect best practice. These infection control policies and procedures are appropriate for the size and complexity of the service and have been provided by Bug control. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |

of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred, provided by an external infection control specialist. The infection control coordinator has completed ongoing infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
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 is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection and is analysed. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary in the electronic database. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised and provides a no restraint environment. There were no residents with restraint and no residents with an enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP) and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.

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 1.2.3.9 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	Health and safety policies include hazard identification and management. Hazard registers have been recorded for the various service areas e.g. clinical, kitchen, housekeeping and laundry. The service uses hot water bottles for those residents who request them. Policy and procedures around the use of the hot water bottles is documented. Staff interviewed were unable to confirm how many residents use the hot water bottles. One resident has sustained a burn from a hot water bottle and this had not been followed up within acceptable timeframes (link 1.3.3.4). There is no record in the resident's care plan around safe use of the hot water bottle. The hazard register includes the use and associated risks of hot water bottles. Staff advise that they check the bottles prior to filling for residents.	There is no record of which residents are using hot water bottles and resident care plans do not have this recorded if in use.	Ensure that there is a list of residents completed who use hot water bottles and that this is recorded in their care plans, including the associated risks of using hot water bottles.

				60 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Low	A missing resident incident occurred in April 2016 that required the Police to be notified. They subsequently conducted a search and the resident was located some distance away from the facility. The Ministry of Health was not informed of this incident.	The Ministry of Health were not notified of a recent incident where the Police were involved and conducted an investigation.	Ensure that relevant authorities are notified where required. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	On the day of audit, the service was using an electronic medication management system for regular medications and paper based medication charts for Warfarin. Not all Warfarin had been prescribed or administered correctly.	Two of sixteen resident files sampled were prescribed Warfarin. One resident was not being administered the correct dose on the correct day. The second resident's Warfarin prescription did not consistently document the dose in milligrams to be administered.	Ensure that all medication is prescribed and administered correctly 30 days
Criterion 1.3.3.4 The service is coordinated in a manner	PA Moderate	The registered and enrolled nurses are responsible for all aspects of clinical assessment and care planning. Residents with an acute change in health condition or post	i) There was no documented follow up by a	i-iii) Ensure that the registered

that promotes continuity in service delivery and promotes a team approach where appropriate.		adverse event were not always followed up or reviewed by a registered nurse in a timely manner.	registered nurse for care issues noted in event/progress notes by care staff for one resident with sore red eyes and one resident with chest pain.

ii) The assessment completed by an enrolled nurse (EN) for a resident who sustained a burn from a burst hot water bottle was not fully documented and the resident was not reviewed by the RN until 10 days after the incident.

iii) The review of residents following adverse events was not completed in a timely manner for four resident incident forms sampled. | nurses review and follow up all clinical issues in a timely manner.

30 days |
| Criterion 1.3.4.2 | PA | The initial care plans were developed from information gathered through interviews with the resident (and where | i) Three of eight files reviewed for | i) Ensure that appropriate |

| The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | Moderate | appropriate the family/whānau) and review of the admission documentation. The resident's temperature, pulse and weight were documented on admission. No other clinical risks assessment tools were used on admission. Not all residents had been reassessed using an appropriate assessment tool where clinically indicated. | residents recently admitted, had no initial assessments (including but not limited to: falls, pressure injury risk, pain, mobility and skin integrity) documented for care needs identified in the admission information.

ii) A falls risk re-assessment was not completed following a fall with injury (rest home tracer). The registered nurses' clinical assessment following the fall with injury was not fully documented.

iii) Three of eight residents identified as at low risk for developing a pressure injury and a low falls risk were given a clinical risk rating with no documented evidence of a clinical | assessment tools are utilised on admission to identify clinical risk and care needs.

ii-iii) Ensure that appropriate clinical assessments tools are used where clinically indicated and all assessments are fully documented, as required by the organisational policy.

iv) Ensure pain assessments are completed for residents reporting pain.

v) Ensure that all initial wound assessments |
|---|---|---|---|---|

			assessment using the appropriate assessment tool, as required by the organisational policy.	are completed and fully documented.
			iv) Four of eight files reviewed had no pain assessments documented for residents noted in the event/progress notes to be having pain.	60 days
			v) Seven of seven initial wound assessments had not been fully documented on the wound care plan.	
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	The registered nurse is responsible for the development of the care plans. The information gathered through the use of the interRAI was not always transferred to the long-term care plan. Short-term care plans were in use but not for all changes in health conditions. The initial, short-term and long-term care plans did not include specific interventions to manage all clinical risks. The activities care plans were documented and listed the resident goals but did not include specific interventions to achieve these goals.	i) Three of eight initial care plans reviewed (for residents recently admitted) lacked sufficient detail to guide the care staff. ii) Five of eight long-term care	i-iii) Ensure that interventions are documented for all assessed care needs and the interventions documented

			plans reviewed had not included the assessment information gathered and care issues identified through the use of the interRAI assessment tool.	include sufficient detail to guide the care staff.
			iii) Four of eight residents with acute changes in health condition did not have short-term care plans documented or where they were documented, they lacked sufficient detail to guide the care staff.	iv) Ensure that the activity care plans include specific interventions to describe how the resident goals will be met. v) Ensure that the activity plans reflect the individual needs of each resident.
			iv) Five of eight activities care plans reviewed did not describe how the resident goals will be met.	60 days
			v) Three of eight activities care plans reviewed did not evidence consideration for the sensory and cultural needs of the residents.	

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 home assistants document bowel activity in the event/progress notes for residents with known bowel management issues. There was no evidence that this information was consistently monitored by the registered nurses. Care requirements documented by allied health care professionals in the event/progress notes were not always transferred to the long-term care plan.	i) Three residents with known history of constipation and bowel disorders had bowel monitoring documented in the event/progress notes. There was no evidence this monitoring was regularly reviewed by a registered nurse. ii) The monitoring of daily food and fluid intake as requested by the dietician for one resident at risk of weight loss had not been documented. iii) Care requirements documented in the progress/event notes by the dietician for a resident who was identified as at risk of weight loss were not transferred to the LTCP.	i) Ensure that all monitoring is regularly reviewed by a registered nurse. ii-iii) Ensure all care requirements requested by allied health care professionals are implemented. 60 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.