Parata Anglican Charitable Trust - Parata Anglican Charitable Trust

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:	Parata Anglican Charitable Trust
Premises audited:	Parata Anglican Charitable Trust
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 September 2016 End date: 15 September 2016

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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

Parata Anglican Care rest home is a charitable trust governed by a board of trustees. The rest home provides care for up to 26 residents. On the day of audit, there were 26 residents.

The manager is an enrolled nurse with many years' experience in aged care management. She is supported by an assistant manager (also an enrolled nurse), two part-time registered nurses, an administrator and long serving staff.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with management, staff, residents, relative and the general practitioner. The residents and relative commented positively on the services and care provided at Parata Anglican Care rest home.

The service has addressed seven of ten findings from the previous certification audit relating to implementation of the quality system, the training programme, and reference checks for new staff, medication prescribing, and restraint monitoring documentation.

Further improvements are required in relation to documentation of progress notes, care-planning interventions, medication management documentation.

There were no new findings identified at this surveillance audit.

Consumer rights

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

Information about the Code of Health and Disability Services Consumers' Rights and related services is readily available to residents and families. There is documented evidence of open disclosure. Complaints processes are implemented and managed in line with the Code of Health and Disability Services Consumers' Rights.

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.

Parata Anglican Care rest home is implementing a quality and risk management system that supports the provision of clinical care. Quality data is collated and discussed at staff meetings. There are human resources policies including recruitment, job descriptions, selection and orientation. A staff training programme is in place. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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 each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts had photo identification and allergy status documented.

The diversional therapist and activity assistant coordinate and implement an activity programme that includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences of the residents. Volunteers are involved in the activity programme.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on site. 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.

Restraint minimisation is practiced and overseen by the registered nurse. There were no residents using enablers and three residents with restraints. Staff receive training and education around restraint minimisation and safe practice and challenging behaviours.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A senior caregiver (with oversight provided by a registered nurse) is the infection control officer. A suite of infection control policies and guidelines meet infection control standards. Surveillance data is collected, collated and displayed for staff.

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	15	0	1	2	0	0
Criteria	0	38	0	1	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	There is a complaints policy to guide practice, which aligns with Right 10 of the Code of Health and Disability Services Consumer Rights. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The complaints register was reviewed. There have been no complaints since the previous audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The manager (who is an enrolled nurse), assistant manager (enrolled nurse), part-time registered nurse and two caregivers interviewed confirm family are kept informed. There was documented evidenced of family notification on the family page within the five files reviewed of any changes to health. Residents and relatives receive regular newsletters. Newsletters are community based and available at the local church. There is access to an interpreter service as required.
Standard 1.2.1:	FA	Parata Anglican Charitable Trust board provides overarching governance to the service, with support provided by a board trustee/administrator. The manager reports to the administrator, who provides the trust board with a

Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		two monthly report. Two experienced registered nurses provide clinical leadership and oversight. The service provides rest home level care for up to 26 residents. On the day of audit, there were 26 residents. All residents were under the ARCC. Parata rest home has an annual quality plan 2016-2017 developed in consultation with the trustees, management and staff. The quality plan includes the aims of the charitable trust, action plan, timeframes and responsibilities. The 2015 quality plan was reviewed in March 2016. The facility is managed by a long-serving manager, who is an enrolled nurse. The assistant manager is the health and safety officer and an enrolled nurse. A full-time administrator is employed to attend to facility business, human resource management and attend the board meetings. The manager reports to the board. The management team is supported by two part-time registered nurses. The manager has completed at least eight hours of professional development in the last year including attending a health and safety legislation update (included information on notifications) and pressure injury prevention and management.
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.	FA	Parata rest home has a quality and risk programme that is being implemented and includes quality goals for 2016 around all areas of service delivery and staff management. The 2015 quality plan and goals have been reviewed and results communicated to staff at the staff meeting as evidenced in meeting minutes. A copy of the reviewed and current quality plan has been made available to all staff. The previous finding around the review and discussion of quality goals has been addressed. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies at staff meetings and are required to sign that they have read meeting minutes and new/reviewed policies. Care planning policies include reference to the use of the InterRAI assessment tool. Quality assurance staff meetings are held three monthly and include health and safety, infection control, restraints/enablers, accidents and incidents, outcomes of internal audits, surveys and any concerns/complaints. Staff interviewed confirmed there is discussion around quality data. The service collates accident/incident and infection control data. Monthly comparisons include trends and analysis. Monthly reports and graphs on accident/incident and infection control data is displayed for staff and are attached to the meeting minutes. The previous finding relating to discussion and documentation around quality data, outcomes of internal audits and surveys has been addressed. A 2016 internal audit programme covers all aspects of the service including environmental, food service, cleaning service, resident care and documentation, medication and infection control. Corrective action plans are

		developed for any partial compliance. Audit summary forms including corrective actions are completed, signed off, displayed for staff and discussed at quality assurance meetings. The previous finding around the completion of corrective action plans has been addressed. The manager advised that residents choose not to have resident meetings. The resident survey was completed June 2016 and results communicated through the resident/relative newsletters as sighted. The relative survey is in progress. The previous finding around communication of survey results has been addressed. The assistant manager/enrolled nurse is the health and safety coordinator and has attended an update to the health and safety legislation in August 2016. Hazard reports are reviewed. The health and safety coordinator provides a monthly report to the quality assurance staff meetings. The hazard register has been reviewed 2016. Falls prevention and management are addressed on an individual basis as part of the care planning process with exceptions (link 1.3.6.1).
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Six accident/incident forms for the month of August 2016 were reviewed. All document timely RN review (including afterhour's assessments) and follow-up within a timely manner. There is documented evidence the family had been notified promptly of incidents/incidents. The service collects incident and accident data and analyses falls according to time and location of fall. Monthly collation includes graphs and trend analysis. An RN monthly report is generated for the management team and quality assurance staff meeting regarding all incidents/accidents. A discussion with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been one section 31 notification since the previous audit.
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 policies to support recruitment practices. Five staff files reviewed (two RNs, one enrolled nurse and two caregivers) contained all relevant employment documentation including reference checks for new employees. The previous finding around reference checks has been addressed. Current practising certificates were sighted for the registered nurses, enrolled nurses and allied health professionals. One part-time RN (three days per week) has completed InterRAI training. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Annual performance appraisals have been completed as scheduled for 2016 to date. Staff complete competencies relevant to their role such as medication competencies. There is an education planner in place, that covers compulsory education requirements. Staff who are unable to

		attend on-site in-service complete a self-learning tool. The previous finding around formal education and attendance records has been addressed. Staff have the opportunity to attend external education.
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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The manager works full-time and is readily available to staff. The manager/enrolled nurse and RNs share the on-call. Caregivers interviewed confirmed the afterhour's staff are accessible afterhours. The residents interviewed inform that there are sufficient staff on duty at all times. The rosters sighted confirmed that sick staff are replaced on the roster. There is a dedicated cleaner on duty seven days.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	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' stations. Other residents or members of the public cannot view sensitive resident information. Resident progress notes lacked a record of care for some shifts. The previous finding remains around progress notes.
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	Medicine management policies and procedures are in line with required guidelines and legislation. The RN checks individualised medication packs on delivery against the pharmacy generated medication charts. The RNs and caregivers complete an annual medication competency and have attended medication education provided by the pharmacist. Caregivers interviewed were aware of the process for reporting any medication errors. All medication is stored safely. The medication fridge has weekly temperature checks conducted, which were within the acceptable range. There was one self-medicating resident with a completed self-medication competency. Ten medication charts reviewed had photo identification and an allergy status recorded. Medication charts met prescribing requirements for regular medications and 'as required' medications. This aspect of the previous audit finding has now been addressed. Not all medications had been administered as prescribed and a shortfall was identified relating to three monthly GP reviews. The previous finding around medicine management remains.

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 are prepared and cooked on-site by two cooks who work a set roster to cover the seven-day week from 7.00am to 1.00pm. The cooks are supported by a morning and afternoon kitchenhand. Food safety training has been completed and one cook is progressing through a recognised course. There is a four weekly seasonal menu. The cook receives a resident dietary profile. Likes, dislikes and dietary preferences are known and accommodated. Currently there are no special diets. Alternative foods are offered for resident dislikes. Modified diets are provided as assessed by the RN. Meals are served from a bain-marie. Fridge, freezer and end-cooked temperatures are taken and recorded daily. Perishable foods sighted in the fridges were dated. Chemicals are stored safely. A cleaning schedule is maintained. Resident provide direct feedback on the meals and food services generally. Residents interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
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	When a resident's condition alters, the registered nurse initiates a review and if required, a GP or nurse specialist consultation. There is documented evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional and GP visits. Discussions with families are documented on the family page within the resident files. Short-term care plans are used for short-term needs, however not all interventions had been documented to meet the resident's current needs. The previous finding remains around documented interventions. Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. A wound assessment chart and ongoing wound evaluations were in place for two residents with wounds. Both wounds had short-term care plans in place. The wound care nurse had been involved in wound care management for a chronic ulcer. The enrolled nurses and RNs have attended wound care management. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, food and fluid input charts and restraint.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery	FA	The service employs a diversional therapist (DT) three days a week (19.5 hours) and an activity assistant for one day per week. The DT has a current first aid certificate. The activity programme is provided from 10.00am to 3.30pm Monday to Friday, with volunteers coordinating activities as per the programme for two days a week. Both activity persons are on duty together for one day per

plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		week, giving residents options of activities to attend. The large daycentre has seating arranged to accommodate small or larger group activities simultaneously. One-on-one time is spent with residents who choose not to attend group activities. The day care centre has a functioning kitchenette area. Activities include exercises, wool craft, reading, knitting for charities, board games and bowls. Community links are maintained with inter-home visits and competitions, speakers, concerts, entertainers and library service. There are weekly bus trips. Church services and Communion are held weekly. Residents provide feedback on the programme through direct feedback and resident surveys. An activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by the RN within three weeks of admission. Three of the five long-term care plans have been evaluated by the RN in consultation with the resident/relative at least six monthly or earlier for any health changes. Two residents had not been at the service long enough for a long-term care plan review. Family had been invited to attend a care plan review and are informed of any changes if unable to attend. Routine InterRAI assessments are completed as part of the six monthly reviews. Written evaluations identify if the desired goals have been met or unmet.
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 facility has a current building warrant of fitness that expires 31 March 2017.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control nurse (oversee RN employed as senior caregiver) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including graphs are available to staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at the quality assurance staff meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. Systems in place are appropriate to the size and complexity of the facility.

specified in the infection control programme.		There has been one notification to public health for one resident with a confirmed notifiable disease.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	A registered nurse oversees the enabler/restraint process within the facility. There are policies around restraint and enablers and the management of residents who may exhibit behaviours that challenge. Enablers are voluntary. The service currently has no residents using an enabler and three residents with bedrails as restraints.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Assessments identify the specific interventions or strategies trialled before implementing restraint. Approved restraints are documented. Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator/RN. There were three residents with bedrails as restraints. Care plans included risks associated with the restraint use and monitoring requirements. The monitoring forms reviewed for three residents documented compliance with the monitoring requirements including frequency and cares carried out during the restraint period. The previous finding around monitoring has been addressed.

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 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	PA Low	Five of five resident files reviewed identified staff designation and signature. Not all entries were timed. On some shifts there was no information recorded.	Some progress notes identified the shift and staff designation only. There was no other information documented for the shift.	Ensure progress notes reflect the care and support provided. 60 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	PA Moderate	Seven of 10 medication charts had been reviewed at least three monthly. Eight medication signing-	1) Three of 10 medication charts had not been reviewed by the GP at least three monthly. 2) Two medication signing sheets identified medications had not been administered as prescribed for warfarin and a dietary supplement.	1) Ensure medication charts are reviewed by the GP at least three monthly;

reconciliation in order to comply with legislation, protocols, and guidelines.		sheets evidenced medications had been administered as prescribed.		and 2) Ensure medications are administered as prescribed. 30 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	Short-term care plans were sighted for infections, lesions, changes of cares and falls. Five of five resident care plans did not reflect the resident current health status.	Interventions, prevention strategies and management plans, had not been documented for five residents for the following: 1) One resident with a chronic respiratory condition (tracer 1.3.3.). 2) One residents with challenging behaviours as identified on a behaviour-monitoring chart. 3) One resident, who experiences chest pain and uses Nitrolingual spray. 4) One resident who is a high falls risk. 5) One resident, who is an insulin dependent diabetic.	Ensure interventions are documented to guide staff in the delivery of care for short-term/long-term supports and needs. 30 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.