

Fraser Manor Limited

Introduction

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

The audit has been conducted by The DAA Group 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:	Fraser Manor Limited
Premises audited:	Fraser Manor Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 October 2016 End date: 17 October 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:	27

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

Fraser Manor continues to provide rest home level care to a maximum of 30 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the District Health Board. There have been no significant changes to the scope or size of the service since the previous audit in 2014. The residents and a family member interviewed on site and a general practitioner interviewed by telephone expressed their satisfaction with the care and quality of services provided.

There were no areas for improvement identified during this audit and all the standards assessed were fully attained.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service demonstrates that it communicates effectively with its residents, their family and allied health professionals when required, in a timely and open manner. Review of the complaints received since the previous audit showed that these were

managed effectively. There have been no known complaints to the Office of the Health and Disability Commissioner (HDC), no coroner's inquests or issues based audits. One matter has involved the nationwide advocacy service. The residents interviewed knew about the complaints process and said they had no hesitation in approaching any staff about their concerns, including the owner and the facility manager

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.		Standards applicable to this service fully attained.
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There have been no changes to the governance structure or within senior management. The owner/operator who is on site most days, has an in-depth knowledge of the services provided and how they impact residents due to frequent and clear communication with the facility manager. Quality and risk management systems were being maintained with all areas of service delivery being regularly monitored. Adverse events are reliably reported, and investigated to determine ways that recurrence could be prevented. People impacted by an adverse event are notified (eg, general practitioners, families). The owner and the facility manager understand their obligations with regard to essential notifications.

Staff were being recruited and managed effectively. Staff training in relevant subject areas has been occurring regularly. There were adequate numbers of skilled and experienced staff on site to meet the needs of the resident group.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the resident.

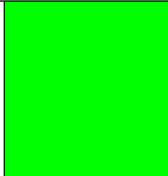
All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, as needed. All care plans are evaluated at least six monthly. The service meets the contractual time frames for all short and long term care plans. The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a four week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness and all interior and exterior areas are being maintained as safe and suitable. There have been some upgrades and improvements to the property since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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On the day of audit there was one resident who required bed rails to be up when sleeping. There were no enablers in use. There was evidence that assessment, consent, approval and monitoring and review occurs in relation to these. Staff training around safe restraint and enabler use continues to be provided regularly.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, 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	16	0	0	0	0	0
Criteria	0	39	0	0	0	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Records and staff and resident interviews showed that the service is managing all complaints received according to its policy and right 10 of the Code. The complaints register was up to date. Residents confirmed knowledge of the ways to lodge a complaint. The 15 complaints logged since the previous audit show that each matter was investigated immediately, and managed effectively for resolution with all parties. There was ongoing communication with all people involved. One matter involved the external advocacy service at a resident's request. The resident concern was interviewed and confirmed that the matter is now resolved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The service continues to promote an environment of good communication. Policies and procedures are in place if the interpreter services are needed to be accessed but this has not been required since the previous audit. A family member interviewed said they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented on the accident/incident form and in the residents' progress notes sighted.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>On the day of audit there were 27 residents who were all over the age of 65 years. Interview with the nurse manager and owner and review of documents showed the quality, risk and business plans have current goals. The owner is on site most days and is kept informed about service delivery and organisational performance.</p> <p>The nurse/facility manager's personnel records reviewed confirmed ongoing performance development in subject areas related to the role. The owner and facility manager are continuing to liaise with other age care providers in the area and have regular contact with their DHB points of contact.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Review of onsite records and staff interviews confirmed that Fraser Manor is maintaining its quality and risk management systems. Policies and procedures are being updated as required to meet legislation and current best practice. Residents confirmed they are consulted about services and are being kept informed at their regular residents' meetings. All quality data continues to be analysed by the facility/nurse manager and reported to staff at their meetings. There is documented evidence of corrective actions on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation.</p> <p>Discussion with the owner revealed how the organisation's annual quality plan, business plan and associated emergency plans identify all actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. The facility manager and owner communicate environmental risks to visitors, staff and residents through notices, or verbally, depending on the nature of the risk. Review of staff meeting minutes showed that health and safety including the hazard register and risks related to residents are discussed. The staff members interviewed said they feel fully informed. Fire drills are occurring at least six monthly, the most recent occurred in September 2016.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported</p>	FA	<p>Interviews revealed that the adverse event reporting system is known by staff and is co-ordinated by the nurse manager. The event records showed that reporting occurs immediately and is investigated to determine cause and prevent or minimise recurrence. The incident form also records who (for example, family, General Practitioner) was notified and when. This was confirmed during telephone interview with the GP. The records showed that analysis of the incident and accidents data was occurring reliably at monthly intervals and that this identified positive or negative trends. There was evidence in staff meeting minutes that trends are reported and discussed along with methods for addressing unwanted trends. Interviews confirmed that the facility manager and owner/operator understand their obligations about essential notifications.</p> <p>There has been no event requiring notification.</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff are being effectively managed. The skills and knowledge required is documented in position descriptions and employment agreements. The nurse manager and a cross section of staff interviewed confirmed they understand their roles, delegated authority and responsibilities. Every job applicant is reference checked and police checked. Staff records contained evidence of curriculum vitae (CVs), educational achievements, and the RNs files had copies of current practising certificate.</p> <p>A new staff member interviewed confirmed they had completed orientation which included essential emergency systems.</p> <p>Individual staff performance appraisals are being conducted annually.</p> <p>The sample of five staff files reviewed confirmed that staff are maintaining knowledge and skills in emergency management, first aid certificates and competencies in medicine administration and attend regular training. Fraser Manor supports its caregivers to achieve qualifications in aged care.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Rosters sighted and interviews with staff confirmed there is an appropriate number of staff on site for all shifts and a RN available on site or on call 24 hours a day seven days a week. Residents interviewed are satisfied with the availability of staff.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	<p>FA</p>	<p>The registered nurse described the processes to ensure safe administration of all medications. This included competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit two residents were self-administering medications and this was in the resident's room in a secure location.</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the treatment room which is locked when not occupied. A locked cupboard is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge with recorded temperatures documented.</p> <p>The facility has implemented an electronic medication charting and management system. The 10 medicine charts sighted have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.</p> <p>There are documented competencies sighted for all staff responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. The cook interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a four week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner also supporting individual residents with different cultural food needs if required. All main meals are supported by morning and afternoon tea which includes home baking.</p> <p>All meals are cooked and served directly from the kitchen and served in the adjacent dining room. Residents have the option of trays in their rooms, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.</p>
<p>Standard 1.3.6:</p>	<p>FA</p>	<p>Clinical management policies and procedures include assessment on admission, weight and bowel management,</p>

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme uses a framework to empower the residents both young and older to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of choices/cultural preferences of the aged care residents.</p> <p>The facility has one activity co-ordinator who works a two week rotation, Monday – Friday and alternative Saturdays, a total of 30 hours per week, and attends regular education/support group sessions related to their role. This role is supported by a health care assistant who works alternating days. The weekly activities plan/calendar sighted was developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activities staff advertises the upcoming activities on the calendar by providing this to residents on the notice board in the facility. The activity co-ordinator visits all the residents each morning to encourage them to partake in the day's activities. Regular activities include daily newspaper reading and different types of exercises, church services, regular visiting entertainment and regular trips out with the support of taxis. The residents also partake once a month in the community, a 65+ club, which involves different activities. There are also specific men and lady's outings. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff throughout the day continue to promote social interaction by inviting and encouraging all residents to join in activities together in the main lounge.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors</p>

		felt included when they visited.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their nurse practitioner (NP) and family/whanau. Short term care plans were sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There is a current building of warrant of fitness which expires in June 2017. Hazard monitoring and preventative maintenance is occurring. New carpet and bathroom upgrades have happened since the previous audit. All external areas investigated were safe for use by the consumer group.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified</p>	FA	<p>All staff are required to take responsibility for surveillance activities. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly and yearly surveillance report. The service monitors skin and soft tissue wounds, pressure injuries, urinary tract infections, oral, eyes, ear, gastroenteritis infections, and scabies. Antibiotic use is also monitored. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff and where appropriate family and resident meetings.</p> <p>The Public Health office and district health board was notified on the 18 March 2014 regarding a gastroenteritis outbreak. Twelve (12) residents and eight (8) staff were affected. A plan was developed, isolation of residents/staff,</p>

<p>in the infection control programme.</p>		<p>and health warning signs/communication were put in place. Cleaning, laundry and personal hygiene were emphasized. The facility was reopened on the 26 March 2014. A corrective action plan was sighted meeting all legislation and standard requirements.</p> <p>The monthly reports identify two residents who are chronically unwell and frequently require antibiotics. Short term and long term care plans sighted evidence interventions in place to reduce and minimise the risk of infection.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There was one restraint (bed rails) in use on the day of the audit for which assessment and consent had been obtained. There were no enablers in use. Education and personnel records showed that staff were attending ongoing education related to restraint minimisation and prevention.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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, there 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.