# Fergusson Home Limited - Fergusson Home and Retirement 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Fergusson Home Limited

**Premises audited:** Fergusson Home and Retirement Village

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 April 2017 End date: 21 April 2017

**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:** 35

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Fergusson Home and Retirement Village (Fergusson Home) provides rest home and hospital level care for up to 44. The service is operated by The Cantabria Group and managed by a nurse manager who is supported by a team of registered and enrolled nurses. With the exception of one resident, resident and families interviewed spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

This audit has resulted in six areas identified for improvement, related to cultural values and beliefs, quality data evaluation, recording of residents’ information, care planning including activities, and hot water temperatures.

## Consumer rights

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

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these rights are respected. Services support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs.

The service has linkages with a range of specialist health care providers to support best practice and meet each resident’s needs.

A complaints register is maintained with complaints resolved effectively. There has been one coroner’s investigation which the service is waiting for documented close off.

## 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. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services, provided to the governing body, is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

There is no private information on public display.

## 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 low risk. |

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. The nursing assessments are conducted using the electronic interRAI tool and the organisation’s own paper based tools. Care plans are individualised, based on a range of information and accommodate any new problems that might arise.

Files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## 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. |

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of audit. A comprehensive assessment, approval and monitoring process is described in policy and staff demonstrated a sound knowledge and understanding of processes should restraint or enablers be required. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests.

## 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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 39 | 0 | 6 | 0 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 6 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **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 | The service has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Education on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records sampled. |
| 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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements, and processes for residents unable to consent are defined and documented, as relevant, in the resident’s record. Staff were observed to gain consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager provided examples of the involvement of Advocacy Services in relation to an internal complaint and resident education/information sessions. |
| 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 | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.  The complaints register reviewed showed that seven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible.  The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and families interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission process. The residents and families interviewed reported that the information was explained to them. The Code is displayed, together with information on advocacy services, how to make a complaint and feedback forms. The advocacy service provides group and one to one education on the Code to residents at least annually. |
| 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 | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room.  Residents are encouraged to maintain their independence by accessing community services and events, participation in clubs of their choosing and activities at other aged care services. The care plans sampled included documentation related to the resident’s abilities, and strategies to maximise independence.  Records sampled confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, although these are not always clearly documented into their care plans or activities plan (refer to 1.1.4.3).  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| 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. | PA Low | There are no known barriers for potential residents who identify as Maori to access the service. The service currently has at least one resident who identifies as Maori. The principles of the Treaty of Waitangi are incorporated into day to day practice, as was the importance of whānau. Individual cultural values and beliefs of residents who identify as Maori were not always clearly recorded in the care plan (refer to 1.1.4.3). A resident interviewed who identifies as Maori, reported overall satisfaction with the supports and services provided. |
| 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 | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions and special needs were included in care plans reviewed (also refer to 1.1.4.3). The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and families stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction/orientation process for staff included education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals (for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons), and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The GP reports they were ‘highly satisfied’ with the quality of care at Fergusson Home.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The resident and family satisfaction survey records satisfaction with the care and services provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and families stated they were kept informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English. Appropriate communication strategies are implemented for residents with non-verbal communication. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the project support advisor and quarterly reports to the board of directors, which includes the owners, showed adequate information to monitor performance is reported, including financial performance, emerging risks, Careerforce information, quality information, policy and procedure reviews, and any issues that occur, such as complaints.  The service is managed by a nurse manager (registered nurse) who holds relevant qualifications and has been in the role for over 10 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular ongoing education covering both clinical and management aspects of the service.  The service holds contracts with the District Health Board for Age Related Residential Care which includes respite for rest home care only. All 35 residents were receiving services under this contract at the time of audit. |
| 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 | When the nurse manager is absent, a staff member who is fully conversant with the role owing to succession planning, carries out all the required duties under delegated authority. They receive assistance from senior members of the Cantabria Group as required. During absences of key clinical staff, the clinical management is overseen by the nurse manager who holds a current practising certificate as a registered nurse. Staff reported the current arrangements work well. |
| 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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, clinical incidents including infections, falls and pressure injuries. Benchmarking is undertaken among the three facilities owned and operated by the Cantabria Group.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at staff and quality meetings, senior management and board level, as appropriate. Staff reported their involvement in quality and risk management activities through internal audit activities. Corrective actions are developed and implemented to address shortfalls. Evaluation of the outcome of actions taken is not consistently documented.  Resident and family satisfaction surveys are completed annually. The most recent survey showed the majority of residents were very happy with services delivered. Two residents who had concerns had them followed up via corrective action planning. For example, one resident was not happy with meal times so an individualised plan for meal times was developed.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the nurse manager, senior management and to the board of trustees.  The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant events made to the Ministry of Health, under section 31 since the previous audit. This sudden death (21 January 2016) resulted in a coroner’s inquest. The letter of closure has yet to be received from the coroner’s office. All actions taken were very clearly documented. |
| 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 | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records were maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.  Continuing education is planned on an annual basis, including mandatory training requirements. This process is managed by the training officer based at the Cantabria Group office. A monthly training calendar was advertised at Fergusson Home. A project to improve staff attendance at in-service education has been undertaken and was working well resulting in higher staff attendance at all in-service offered. Attendance numbers improved from between 35% to more than double.  Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member from the Cantabria Group is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate, 24/7. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | All necessary demographic and personal information was fully completed in the residents’ files sampled. There were some inconsistencies in the health information recorded and where information is located in the resident’s files and dating of some documents. The progress notes were entered daily, were legible with the name and designation of the person making the entry identifiable. There is a signature register on each page of the progress notes.  Archived records were securely stored onsite and readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Residents enter the service when the required rest home level of care assessment is confirmed by the local Needs Assessment and Service Coordination (NASC) service. The NASC and Eldernet service is provided with current information about the services and any vacancies. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files sampled contained completed NASC assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the families. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the resident’s file. An example reviewed of a patient recently transferred to the local acute care facility showed the yellow envelope system and transfer processes were utilised. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The manager (RN) and an enrolled nurse checks medications against the prescription. All medications sighted were within current use by dates.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.  The records reviewed of temperatures for the medicine fridge and the medication room were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for as required (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines.  There were no residents self-administering medications at the time of audit. Appropriate processes and policies were in place if a resident is assessed as appropriate to self-administer their medicines.  There was an implemented process for review of any medication errors through the adverse event reporting system. |
| 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 | The food service is provided on site by a qualified chef/cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The Cantabria Group kitchen manager provides guidance for the menu and kitchen service at Fergusson Home. The menu is an organisational wide one, which follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen staff have completed relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| 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 | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found in consultation with the resident and whānau/family. If entry is declined, this information is recorded on the enquiry form. Examples of this occurring were discussed, when a resident required hospital level of care. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools (such as, pain scale, falls risk, skin integrity and nutritional screening), to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. In one of the six files sampled, the interRAI was not released till six weeks after the resident’s permanent admission.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. There were inconsistencies in where information was recorded in the resident’s files. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was reflective of their needs. It was noted that although the interventions were reflective of the resident’s needs, the document were followed, and care was of a high standard. Care staff confirmed that care was flexible based on the resident’s needs and requests. A range of equipment and resources was available, suited to the rest home level of care provided and in accordance with the residents’ needs. |
| 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. | PA Low | A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are reviewed six monthly, though some did not have a detailed evaluation. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident’s care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. The evaluation on the care plans described how the resident was progressing. (Refer to 1.3.7.1 for evaluation of the activities plans).  Where progress is different from expected, the service responds by initiating changes to the plan of care or use of short term care plans. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| 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 | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has several ‘house doctors’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to respiratory specialists, dentist, podiatry and diabetic specialists. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill occurred.  There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 12 October 2017) was publicly displayed.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts were made to ensure the environment was hazard free, that residents were safe and independence promoted.  External areas were safely maintained and appropriate to the resident groups and setting.  Residents confirmed they knew the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they were happy with the environment. |
| 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. | PA Low | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes visitor and staff toilets. All bedrooms have full ensuites. The bedroom ensuites are being systematically upgraded and 15 had been completed at the time of audit. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. If hot water temperatures exceed the required safe level for residential care this has not been fully addressed. |
| 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 | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are single accommodation at the time of audit. There are four bedrooms which can be used as double bedrooms and should this occur approval is sought from the resident and family/whanau members. The nurse manager stated the shared rooms would only be used for couples who choose to share a room. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of 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 | Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. There are three lounge areas, one large lounge and two smaller lounges, one of which is a dedicated library area. Furniture is appropriate to the setting and residents’ needs. |
| 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 | Laundry is undertaken on site by a dedicated laundry team. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. A recent project related to the use of individual laundry bags has been completed and residents and staff interviewed were very happy with the new process.  There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through the internal audit programme and chemical use by the chemical provider. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 1 April 2002. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 5 April 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for the capacity of 44 residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by gas heated hot water radiators in residents’ rooms and electric heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a 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 | The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from an external consultant and the Cantabria Group management team and organisational wide infection control coordinator. The infection control programme and manual are reviewed annually.  A registered nurse is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the Fergusson Home’s manager and the Cantabria Group management team.  Signage at the main entrance to the facility requests anyone who is, or has been, unwell, not to enter. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. |
| 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 facility and organisational wide infection control group ensures that appropriate information resources are available to staff, that staff are educated in infection control principles and that the infection control programme is maintained.  The Fergusson Home’s infection control coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for two months. They have completed a post graduate qualification in infection prevention and control. Additional support and information is accessed from the Cantabria Group infection control coordinator, infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The facility coordinator has access to residents’ records and diagnostic results to provide the GP with the information when it comes in.  The facility infection control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| 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 of service provided. | FA | Policies and procedures are clearly documented to guide staff with relevant legislation and current good practice on infection prevention and control.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as good hand-washing technique, use of disposable aprons and gloves. Hand washing facilities are available in each resident’s room and staff office space. Staff verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and in ongoing education sessions. Education is provided by the Cantabria Group infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, cough etiquette, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| 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 | The Cantabria Group policies described the types of infections and standardised definitions of the infections that require surveillance. The types of infections included in the monitoring are appropriate to the rest home setting.  It is the responsibility of the Fergusson Home’s infection control coordinator to gather and record infection data. The Fergusson Home’s infection control coordinator provides a summary chart of all infections and antibiotic prescribing to the Cantabria Group infection control coordinator. All results are collected and benchmarked with the other Cantabria Group facilities by the organisational infection control coordinator. This is analysed monthly, with a further three monthly review at the health and safety committee meetings (or sooner if significant), and recommendations are made to the manager/staff at Fergusson Home. The staff meeting minutes sampled evidence analysis, actions taken and outcomes of the infection surveillance.  All initial resident infections are recorded in the resident’s file and medical personnel are contacted so an appropriate treatment regime can be instigated. Further information relating to the resident’s infection is recorded on an ongoing basis in the resident’s notes and short term care plans so the infection can be monitored.  Monthly surveillance data records when there has been an increase in infections and actions are implemented to reduce reoccurrence. There could be further strengthening of the evaluation of the infection control data, as some months have a detailed evaluation, while other have a breakdown of the numbers of infections, with no meaningful evaluation (refer to 1.2.3.6). |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Policy was reviewed in April 2016. The restraint coordinator (nurse manager) would provide support and oversight for enabler and restraint management in the facility should it be required. They demonstrated a sound understanding of the organisation’s policies, procedures and practice and role and responsibilities.  On the day of audit, the facility was restraint and enabler free. Restraint has not been used since the previous audit. Enablers, as described in policy, are the least restrictive and used voluntarily at their request. This was confirmed by staff, in meeting minutes and the annual quality review sighted. All required documents were available and discussed at annual staff education should they be required. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs. | PA Low | Guidance on Tikanga best practice is available in policy and is supported by staff who identify as Māori. There is a current Māori health plan developed with input from cultural advisers. The file reviewed of a resident who identified as Maori, did not have clear guidance in their care plan on how to specifically incorporate their values and beliefs into their service delivery. There was a generalised statement to ensure they receive culturally appropriate services, with no specific details recorded. The care plan records the resident’s iwi affiliations. Care staff interviewed were aware of the individual resident’s cultural needs or that the resident identified as being Maori. The resident reported that they have had difficulty maintaining their links with the marae and church due to transportation difficulty. The resident did report that they felt safe at Fergusson Home and overall were satisfied with care and support provided. | The documentation in the care plan sampled of a resident who identified as Maori did not have details of how their individual values and beliefs are to be met. | Provide evidence that the care plan records how the needs of Maori residents are met.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality data is collected for infection control, incidents and accidents, complaints, health and safety, falls and internal audit results. It is analysed and results are shared with service providers and residents where appropriate. Whilst evaluation of the data was evident, documentation was not consistently completed. For example, testing of hot water temperatures showed two bedrooms to have water which did not meet the required temperature. It was rechecked and still remained high. No other documentation was evident.  Projects are put in place as required. For example, in an aim to increase staff in-service education attendance, the service worked with the training officer to find ways to increase attendance. The evaluation does not clearly identify the increase in numbers of attendance. When reviewed at the time of audit, it was evident that the increase gained was very high, in some cases over 100% increase of staff attendance. The evaluation merely stated ‘review of staff in-service records’. | Documentation of data evaluation is not consistently undertaken to a level which describes the outcome of the actions taken. | Provide evidence that quality improvement data evaluation is documented to show how it is used to improve services as required.  180 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 | Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information. The service was not able to gain access to an interRAI assessment of a resident admitted for permanent placement on 1 January 2017 until 9 February 2017, which then delayed the assessment and long term care plan development. Three of the residents’ files sampled had inconsistencies in where information was recorded, these residents required wound care, with some information recorded on the wound treatment plan and other information recorded in the progress notes. One of the resident’s files sampled had a quick reference care plan which was not dated. Staff were accessing obsolete documents, for example, the resident incident and accident data reporting form and the hot water monitoring form. These forms were replaced at the time of audit. | Current documents are not consistently used to record data/information. In three of the six files sampled, Information is recorded in inconsistent places. | Provide evidence that current documents are used and information is recorded consistently.  180 days |
| 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 Low | Although there was accurate information in the resident’s files sampled, it was difficult to establish what was the most recent information due to inconsistencies in where information was recorded. Three of the residents’ files sampled had inconsistencies in wound care documentation, with some information recorded on the wound treatment plan and other information recorded in the progress notes. One of the resident’s file sampled had a quick reference care plan updated after an admission to hospital, while the long-term care plan contained conflicting information and the short-term care plan for the changes was not able to be located (the manager reports that a short-term care was completed that reflected the changes). | Information is inconsistently recorded in the care plans, treatment plans, quick reference care plans and progress notes. | Provide evidence that documented information is consistent.  180 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Activities reflect residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents interviewed (including a younger resident) confirmed they find the programme of interest to them.  Two of the six activity plans in the residents’ files sampled had aspects of their activities plan with some details of the resident progress towards meeting their goals. The evaluations in four of the six individual activities plans record the evaluation with a statement such as “evaluated, no change’, the date and the staff members name and signature. | Four of the six activities plan sampled did not evidence an evaluation of the resident’s progress towards meeting their individual activities goals. | Provide evidence that all contractual requirements are met regarding the evaluation of activities plans.  180 days |
| Criterion 1.4.3.1  There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Low | There are adequate numbers of toilets with all bedrooms having full ensuites. There is a dedicated staff bathroom and visitor toilet. Hot water temperatures are undertaken monthly and the form used to record these identifies that hot water temperature for resident use is to remain below 45oCelcius. Recordings identified that hot water is not always delivered within the required temperature. When checked on the day of audit the hot water recording exceeded 50o Celsius. | Two bedrooms had recorded hot water temperatures of 50o Celsius or above twice and no corrective action had been taken. | Provide evidence that corrective measures are taken when hot temperatures are above the acceptable limit.  180 days |

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

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

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

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

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End of the report.