

# J & R Manuel Limited - Phoenix House Resthome and Hospital

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	J & R Manuel Limited
<b>Premises audited:</b>	Phoenix House Resthome and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 29 June 2017    End date: 30 June 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	28

# Executive summary of the audit

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## 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

Phoenix House Rest Home and Hospital is privately owned and operated and cares for up to 30 residents requiring hospital and rest home level care. On the day of the audit, there were 28 residents. The service is managed by a facility manager who has been in the role since November 2016 and is supported by the owner director and a financial manager. Residents and family and the GP interviewed, spoke very highly about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the quality and risk management programme.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

The facility has embedded the interRAI assessment protocols within its current documentation. Care plans were individualised and comprehensively completed in all resident files reviewed. 'At risk' residents were identified and monitoring strategies were implemented and regularly evaluated.

## 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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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family report that communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. The manager is responsible for the day-to-day operations of the care facility. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice.

Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

## 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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There is a comprehensive admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for the administration of medicines and complete education and medication competencies. Medication charts are reviewed three-monthly by the GP.

The recreational therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

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

## 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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are no ensembles but there are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

## 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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There are policies and procedures on safe restraint use and enablers. Two registered nurses share the restraint coordinator role. There were three residents voluntarily using enablers and two residents with restraints. Staff receive training around restraint and behaviours that challenge.

## Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	0	101	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Consumers' Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. One facility manager, one owner director, four caregivers, three registered nurses, and one recreational therapist interviewed, confirmed their understanding of the Code and provided examples of how the Code is applied to residents' cares. Staff receive training about the Code during their induction to the service. This training continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (three hospital - including one long-term support - chronic health conditions agreement, and three rest home including one resident admitted for respite care). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' charts.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. An advocacy poster is displayed in a visible location in both Māori and English. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Education is provided by the local HDC advocacy service.</p> <p>Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with the residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Examples include van outings, and church services, attendance at local art exhibitions and local theatre, and Matariki celebrations. Local entertainers visit the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and families/whānau during entry to the service. Access to complaints forms are located at reception. A complaints register is in place, however there have been no verbal or written complaints since 1995. A small sample of residents are surveyed on a continuous basis with all residents being surveyed at least every 12 months. Any issues identified are addressed quickly.</p> <p>Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. They advised that they had no complaints or concerns about the service and found the staff and managers very approachable.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The facility manager discusses aspects of the Code with residents and their family/whānau on admission. The Code is displayed in English and Māori throughout the facility. All residents interviewed (four rest home and two hospital) and three family/whānau interviewed (one hospital and two rest home) reported that the residents' rights were being upheld by the service.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors.</p> <p>The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families/whānau interviewed confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.</p> <p>Over 50% of staff at Phoenix House identify as Māori and have strong links with the local iwi (Ngati Maru, Ngati Whanaunga, Ngati Tamatera and Ngati Pukenga) and Hauraki Māori Trust Board. Staff regularly speak Te Reo with the Māori residents.</p> <p>Local kaumātua are available to support residents and the facility when required (eg, to bless rooms, to support residents requiring palliative care, to visit family members etc).</p> <p>Cultural values and beliefs that are identified through the assessment process are documented in the resident's care plan. There were seven residents living at the facility who identified as Māori. The Māori residents interviewed confirmed that their cultural values and beliefs were met, and Tikanga principles were imbedded in the care practices in use.</p> <p>Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family/whānau and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, as evidenced in all six care plans reviewed (three rest home - including one resident admitted on a respite</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>agreement and three hospital - including one resident admitted under a long-term support - chronic health condition agreement). Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in the code of conduct. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has a strong focus on quality care and a number of areas of good practice were evident. The service has implemented a falls reduction project which has included staff education on falls prevention and the mechanics of mobilisation, the installation of non-skid carpet, and conversations about all falls at staff handovers and staff meetings. The service also had a focus on the reduction of skin tears, including improved manual handling techniques and education on nutrition and hydration. Staff are now paid to attend education and the service has implemented access to on-line learning for all staff. Staff attendance at education ranges from 37% to 100%. These initiatives are beginning to show improved outcomes for residents.</p> <p>The service is proactive in listening to the resident's requests including rostering one additional staff member over meal times. The residents and families interviewed confirmed that they have no complaints with any aspects of the service.</p> <p>A registered nurse is onsite 24 hours a day, seven days a week. There are three GP practices in Coromandel who provide service to the facility. Hospital residents are reviewed by the GP at least monthly and rest home residents are reviewed at least every three months.</p> <p>The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits (gerontology nurse specialists and wound care specialist nurse). Support is also provided through Hospice New Zealand. A physiotherapist visits the service for 1 hour per week and massage therapy is provided.</p> <p>A van is on site for regular outings. Residents and family/whānau interviewed reported that they are very satisfied with the services received and find the management team very approachable. A resident/family satisfaction survey is completed annually and confirmed satisfaction with the services received.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families/whānau have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Family/whānau document the circumstances and timeframes they wish to be contacted, regarding the notification of a change in health condition or an adverse event. The accident/incident forms reviewed reflected documented evidence of families/whānau being informed following an adverse event. Families/whānau interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. A family/whānau communication sheet is held in the front of the residents' files.</p> <p>An interpreter service is available and accessible if required, through the DHB. Families/whānau and staff are utilised in the first instance.</p>
<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>	<p>FA</p>	<p>Phoenix House is a family owned and operated facility that was established in 1987. The original owners sold the business to their daughter and son-in-law in 2009. The facility manager receives support from the previous owner who is the financial manager and the current owner/director. Both the owner/director and the financial manager are registered nurses with current annual practicing certificates. The facility manager is a registered nurse (RN) with 30 years of nursing experience in the community and hospital setting and has been in a leadership role at this facility since November 2016.</p> <p>The facility provides care for up to 30 residents at rest home and hospital level of care. There were 28 residents on the day of audit. There were 18 rest home residents including one resident admitted under a primary care contract and one resident admitted under a respite care agreement. There were 10 hospital level residents including one resident admitted under the long-term support - chronic health conditions agreement. The remaining residents were all under the ARRC agreement. The service also has a transitional care service agreement and a day care and end of life care contract. There were no residents being funded by the transitional care or end of life care service agreement on the day of audit.</p> <p>An annual business plan has been developed that includes a philosophy, values and measurable goals. Business goals have been documented for 2017 and are being implemented.</p> <p>Both the owner/director and the facility manager have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>During the absence of the manager the owner director and the financial manager (the previous owner) who are both RNs with current APCs assume responsibilities.</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>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the facility manager, owner director, registered nurses, care staff, one cook, and one cleaner, reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to InterRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.</p> <p>Quality data collected is collated and analysed. Quality data is regularly communicated to staff via monthly staff meetings, and a copy of the previous meeting minutes are kept in the staff room.</p> <p>An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions being signed off at staff meetings to evidence their implementation. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions. Quality improvements made since the last audit included (but not limited to) insulating the older part of the building, painting throughout, replacing the Feltex in the main building area, putting non-slip coverings on the external ramps and the installation of Wi-Fi.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (registered nurse) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review March 2017).</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 to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all ten accident/incident forms selected for review.</p> <p>Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The manager is aware of the requirement to notify relevant authorities in relation to essential notifications.</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>There are human resource management policies in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in six staff files randomly selected for review (facility manager, registered nurse, two caregivers, recreational therapist and cook).</p> <p>Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all six staff files. Annual staff appraisals were up-to-date.</p> <p>An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including (but not limited to) nurse specialists, Aged Concern and the Health and Disability Advocacy Service. The service also has access to an aged care on-line learning programme.</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>Phoenix House policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents.</p> <p>There is a registered nurse rostered on each shift for 28 residents (18 rest home, 10 hospital residents).</p> <p>On an am shift there are five caregivers - two long, and two short shifts, in addition to a cleaner who completes caregiving duties from 0700 to 0900. The cleaner then commences the cleaning tasks. On a pm shift, there are three caregivers -two long and one short shift. On a night shift, there is one caregiver. Extra staff can be called on for increased resident requirements.</p> <p>Activities staff are rostered on five days a week. A morning caregiver completes the laundry, and reports there is adequate time allocated for this.</p> <p>Interviews with staff, residents and family/whānau members identified that staffing is adequate to meet the</p>

		needs of residents.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the carer, and include their designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. All nine admission agreements viewed (including respite) were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. Respite residents have their discharge recorded in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There were no standing orders.</p> <p>The facility uses a medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications in the hospital and rest home. Staff attend annual education by Medico who also check medication competency. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature</p>

<p>practice guidelines.</p>		<p>is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on a medication signing sheet. Twelve medication charts were reviewed (six hospital - including one long-term support - chronic health conditions and six rest home – including one respite). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</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>The service has two cooks who cover Monday to Friday and two cooks who cover Saturday and Sunday. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from a bain marie in all dining rooms. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked and these were all within safe limits. The bain marie temperature is also checked. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is approved by a dietitian. All resident/families interviewed were very satisfied with the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and where required, assessments that were reviewed at least six-monthly or when there was a change to a resident's health condition. The interRAI assessment tool is</p>

and recorded in a timely manner.		implemented. InterRAI assessments had been completed for all long-term residents whose files were sampled. Care plans sampled were developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, massage therapist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently five wounds and one pressure injury being managed. One wound has had input from the GP and wound care specialist.</p> <p>One resident has a Portacath in situ. There is a protocol for care of the Portacath in place and assistance from the specialist nurse at WDH B is available if required.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	<p>There are three recreational therapists. One works six hours weekly, one eight and a half hours weekly and one nine hours weekly. On the days of audit residents were observed participating in exercises, listening to music and poetry and assisting with household jobs.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>tailored to residents' needs. These include exercises, brain teasers, news from the NZ Herald, music, walks outside and games.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are no church services held in the facility but family/whānau take residents out to church and the priest and minister visit.</p> <p>Each area has at least one van outing three weekly except for the more independent residents in one area who go out weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and Matariki are celebrated.</p> <p>The facility has four cats and one dog, all of whom the residents take great joy from.</p> <p>There is community input from the local marae and the RSA. The long-term chronic care resident attends a community craft group twice weekly.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held six-monthly and are open for families to attend.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The five long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home and one monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to plastics and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and face shields are available for staff.</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>The building holds a current warrant of fitness which expires 27 June 2018. There is no maintenance person on-site but the facility manager or registered nurse phones contractors when maintenance is required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted and communal showers and toilets have non-slip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>There are no ensuites. All rooms share communal showers and toilets. Fixtures, fittings and flooring are appropriate. There is a hole in the wall of one shower and a builder has already been booked to repair this. Toilet/shower facilities are easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs and a hoist if appropriate. There are privacy signs on all shower/toilet doors.</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are single. They are sufficiently spacious in the rest home and hospital to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
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	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. One lounge opens out onto an attractive courtyard/garden area. There are dining rooms in each wing.
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 done on-site by a caregiver who works a morning shift in the hospital and a laundry shift after lunch. The laundry is divided into a 'dirty' and 'clean' area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away in the cleaner's room as sighted on the day of the audit. Cleaning is done by a caregiver who works in the hospital till 0900 and then cleans for the remainder of the shift. There is a sluice room for the disposal of soiled water or waste. The sluice room and the laundry are kept closed when not in use.
Standard 1.4.7: Essential, Emergency, And Security	FA	Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas barbeque is available. The service have their own generator which is checked monthly.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.</p> <p>There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Phoenix House Rest Home and Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from all staff as members of the infection control team. Infection control is discussed at the staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually (last reviewed March 2017).</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>A registered nurse is the designated infection control (IC) coordinator with support from the facility manager. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>There are Phoenix House Rest Home and Hospital infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed education in infection control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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 in the</p>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p>

infection control programme.		There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint minimisation and safe practice. The policy states that the facility prefers no or minimal restraint. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were two restraints and three enablers in use. All are in the hospital. The three residents using enablers had given consent voluntarily.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	There is a restraint and enabler register. Documentation for one restraint and one enabler was reviewed and this evidenced assessment, consent, planning, monitoring and review of the restraints/enablers. Restraint education is completed annually. Caregivers interviewed understood the restraint process.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessment is completed by registered nurses. All appropriate factors such as risk and alternative strategies are documented. Residents are given full explanations of what restraint involves before signing consent.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint is only used after alternative strategies have been attempted and proven unsuccessful. Careful monitoring by all staff ensures residents being restrained are safe at all times. Monitoring is documented on a monitoring form. There have been no injuries from restraint use. There is a restraint register in place.

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Documentation for the one restraint file reviewed evidenced that each episode of restraint is evaluated on the restraint monitoring form. There had been no changes made to restraint plans but the registered nurse interviewed stated that this would occur if required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint is discussed at quality meetings and by the two registered nurses responsible for restraint. Both the registered nurses stated that they look at trends and that there has been no increase in the use of restraint.</p>

## Specific results for criterion where corrective actions are required

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

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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
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End of the report.