

# Fairview Care Limited - Fairview Care

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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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Fairview Care Limited
<b>Premises audited:</b>	Fairview Care
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 25 July 2017    End date: 26 July 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	44

# 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

Fairview Care provides rest home and hospital level care for up to 47 residents. The service is privately owned and operated with a Chief Executive Officer (CEO) who is the representative for the operators. The facility is managed by the Sales and Administration Manager and the Care Manager who is a registered nurse. Both the managers have held other positions at the facility, with their new management roles being established in May 2017. Residents and families 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, family members, management, staff, the CEO and contracted allied health providers. The general practitioner was not available for interview on the days of audit.

This audit has resulted in all requirements being fully met.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

There were no residents at Fairview Care who identified as Maori. There is a Maori Health Plan and policies and procedures in place to guide staff should this be required. There was no evidence of abuse, neglect or discrimination and staff interviewed understood and implemented related policies. Professional boundaries are understood and maintained by staff.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively. At the time of audit, there is one open complaint, received via the Waitemata District Health Board (WDHB), awaiting a response from the DHB.

## 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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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 undertaken. Two suitably qualified persons manage the day to day operations of 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 were 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.

Residents` information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents` records are maintained using integrated electronic and hard copy records.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident and family to facilitate the admission.

Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and two designated general practitioners. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans reviewed are individualised and based on an integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents` files reviewed demonstrated that needs, goals and outcomes were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and

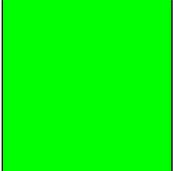
involved in the care planning and evaluation and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers provided.

The planned activities programme provides residents with a variety of individual and group activities and maintains their links with the community. A contracted service is used for van outings in the community fortnightly.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses only, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. 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.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is 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.
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The organisation has implemented policies and procedures that support a restraint free environment. Seven enablers and no restraints were in use at the time of audit. A comprehensive assessment is undertaken prior to the use of enablers. Appropriate approval, review and monitoring process are fully described in policy should restraint be required. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme and co-ordinator role is shared by two registered nurses. The programme aims to prevent and manage infections. Specialist infection prevention and control advice is able to be accessed from the district health board, a community microbiologist, the general practitioners and

an infectious disease physician at the DHB. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, analysed and trended and results are reported through all levels of the organisation Follow-up action is taken as 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	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>Fairview Care 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. Training 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.</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>Nursing and healthcare assistants interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings</p> <p>Documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and was documented where relevant in the individual resident's records reviewed. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional pamphlets were available at reception. Family members and residents interviewed were aware of the Advocacy Service, how to access this and their right to have support persons/representatives as they wished.</p> <p>Staff were aware of how to access the advocacy service if needed.</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>Residents are assisted to maximise their potential, maintain their independence and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents` family and friends. Family members interviewed stated they felt welcome when they visited Fairview Care and felt comfortable when dealing with management and staff.</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 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.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that for five of the complaints actions taken, through to an agreed resolution, are documented and completed within the timeframes. Two of the six complaints were via the WDHB. One was opened on the 16 May 2016 and closed on 6 January 2017 as confirmed in documentation sighted. A detailed completed corrective action plan was sighted. The second WDHB complaint was received by the facility on 29 June 2017 and a reply has been sent to the WDHB covering all issues raised. The facility is awaiting a response.</p> <p>For internal complaints, action plans show any required follow-up and improvements have been made where possible. All internal complaints have been resolved. The care 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.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service through the information package provided as part of the admission process and the discussions with the registered nurses. The staff also explained how to make a complaint and the location of the feedback forms. The Code was displayed in all service areas and at the reception. There is a pamphlet stand at reception with information about complaints, advocacy services and a booklet about the services provided.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately and when exchanging verbal information). All residents have their own private room. Consent is obtained as part of the admission process to have the resident`s name on the door of their room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and participation in clubs of their choosing. Each care plan included documentation related to the resident`s abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident`s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their individual care plan</p> <p>Staff understood the service`s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis as confirmed in the staff training records reviewed.</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>There were no residents or staff in the service at the time of audit who identify as Maori. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of family/whanau to residents. There is a Maori health plan developed to guide staff. Cultural advisers can be sought through the DHB if and when required. Guidance on tikanga best practice is available and accessible in the service policy manual. Staff interviewed have a good understanding of tikanga and stated that they would respect the individual cultural needs for any Maori resident admitted for ongoing care and management.</p>
<p>Standard 1.1.6: Recognition And</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff</p>

<p>Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>respected these. Resident`s personal preferences, required interventions and special needs were included in all care plans reviewed. A resident satisfaction survey includes evaluation of how well residents` cultural needs are met and this supported that individual needs are being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe and secure.</p> <p>The staff induction/orientation process includes education related to professional boundaries and expected behaviours. All registered nurses have completed the required training on professional boundaries as required for maintaining their annual practising certificates. Staff are provided with a Code of conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies and procedures and input from external specialist services and allied health professionals, for example, the hospice, diabetes nurse specialists, the gerontology nurse specialist from the DHB, physiotherapist, wound care nurse specialist. The community dietitian and services for older people, inclusive of mental health and other specialist groups, are also available on a referral basis when needed.</p> <p>Staff interviewed reported they receive management support for external education and access their own professional networks to support contemporary good practice.</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>Residents and family members interviewed stated they were kept well informed about any changes to their/their relative`s condition and health status and 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. Any communication with family is recorded on the family contact record in the front of each resident`s records reviewed. There was also evidence of resident/family input into care planning and care plan reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

		<p>Interpreter services are able to be accessed through the DHB when required. Staff knew how to do so, although reported this rarely occurs due to staff being able to provide interpretation as and when needed, the use of family members and other means of communication for residents for whom English is not their first language.</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>	FA	<p>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 minutes and quality and risk data is reported to the CEO monthly. This provides adequate information to monitor performance. The CEO reports to the board and this includes emerging risks and issues that arise.</p> <p>The service is managed by two managers. The care manager (RN) is responsible for clinical issues and holds a post-graduate master's degree in nursing. The sales and administration manager is responsible for other matters and non-clinical staff. The sales/administration manager has worked at the facility for eight years and the care manager for three years and are currently undertaking a management leadership course for which they have completed three papers. Both managers have held other roles in the organisation and have been in their management roles since May 2017. They maintain ongoing education related to their roles. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The managers confirmed knowledge of the sector, regulatory and reporting requirements. The managers feel supported by the CEO and other senior members of staff who work in the village located in the same building.</p> <p>The service holds a WDHB contract for the provision of Age Related Residential Care Services which all 44 current residents were receiving services under at the time of audit. The WDHB have a primary options contract with local primary health organisations and they sometimes refer these residents to Fairview Care. This contract was not being utilised at the time of audit.</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</p>	FA	<p>When the care manager is absent, the most senior RN carries out the clinical aspects of the role and when the sales and administrator manager is absent the administrator undertakes the required tasks. Management staff have not yet taken any leave but confirmed that delegated authority of their roles will only be undertaken by competent, experienced and appropriately trained staff.</p>

services to consumers.		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>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, monitoring of outcomes, clinical incidents including infections, bruising, skin tears and wounds.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at all levels of services and at all staff meetings. A copy of meeting minutes and quality data is provided to the CEO monthly. Also, the two managers have a weekly informal catch-up with the CEO and the sessions are diarised but not formally minuted. Staff reported their involvement in quality and risk management activities through special projects, such as the reduction of bruising, audit activities, and corrective action follow-ups. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed six weeks following admission and then in February each year. The most recent survey showed that issues raised are fully addressed and if the person who raised the issue is identified they are fully informed of the actions taken and the outcome. This was confirmed during family and resident interviews.</p> <p>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.</p> <p>The managers described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The managers are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. A detailed 'Work Safe' programme is in place.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	FA	<p>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 to be taken are documented in the resident's progress notes, care plans are changed as required and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the care manager and collated information is shared with all staff at meetings.</p> <p>The care manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. Two complaints received by the WDHB had been fully documented with all actions required to date completed. Refer comments in criterion 1.1.13.</p>

<p><b>Standard 1.2.7: Human Resource Management</b></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>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 are maintained.</p> <p>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.</p> <p>Continuing education is planned on a quarterly basis, including mandatory training requirements. 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 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. Three RNs hold full competencies and two further RNs are undertaking their interRAI training. (All residents had a current interRAI assessment). Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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. 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 interviewed supported this. Observations and review of a six weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage at the facility.</p>
<p><b>Standard 1.2.9: Consumer Information Management Systems</b></p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential,</p>	<p>FA</p>	<p>The service is changing over from hard copy records to an electronic system. Since 10 July 2017, the personal information records, assessment records, care plans and progress records are all maintained electronically. The next stage is the transferring of the clinical/medical records which are being currently scanned into the system along with diagnostic results, referrals to other health providers and general information and communication records. The general practitioner is already entering clinical information onto the new system. Training sessions are being held on a regular basis, as each section of records is transferred into the new system.</p>

and accessible when required.		<p>The national health index number for each individual resident is recorded on all residents' information as sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files reviewed. The hard copy records contain minimal records; however each page is labelled, is legible and all entries are signed with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily able to be retrieved using an appropriate system if required. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>The residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Co-ordination (NASC) Service. The nurse manager or registered nurses (RNs) are responsible for the admission process. There is a comprehensive information pack for all new residents which includes the mission statement, philosophy, complaints/concerns and where the forms are located in the facility. Information about cultural support and the general practitioner (GP) visit days are included in the information provided to the resident/family/representative. The organisation seeks updated information from the NASC and/or the GP for residents accessing respite care.</p> <p>Family members interviewed stated that they were satisfied with the admission process and the information that had been made available to them on admission. Records reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</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>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 along with all relevant information about the resident to facilitate transfer of residents to and from acute care services. There is open communication between services, the resident and the family. At the time of transition between services, appropriate information, including a copy of the medication records is provided for the ongoing management of the resident. All referrals are documented in the progress records. Family of the residents transferred to the DHB are kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed were registered nurses and both 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.</p> <p>Medications are supplied to the facility from a contracted pharmacist in a pre-packaged format. These medication are checked by the registered nurses against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request and pharmacy audits are performed six-monthly.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two registered nurses weekly as recorded and verified.</p> <p>The records of temperatures for the medicine fridge and the medication room were within the recommended range.</p> <p>Good prescribing practices were noted and verified with the pharmacy audit outcomes. All requirements for pro re nata (PRN) medicines were met. The required three-monthly GP review is consistently recorded on the medicine chart.</p> <p>There are no residents who self-administer medications at the time of audit. Appropriate policies are in place to ensure this is managed if needed in a safe manner.</p> <p>Medication errors are reported to the nurse manager on an incident form. The resident and/or designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>There is only one standing order used for management of anticoagulant medication which is current and complies with guidelines.</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 food service has recently changed over from using a contracted service provider back to the organisation employing a qualified chef, a senior cook and kitchen team. This change occurred 1 June 2017. The same team are now employed by the service provider, with the addition of the experienced cook. The services provided are in line with recognised nutritional guidelines for older people. The four-week menu plans have recently been reviewed by a contracted dietitian. Any recommendations have been implemented.</p> <p>The chef interviewed is responsible for all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal. All current legislation and guidelines meet compliance requirements. The service operates with an approved food safety plan and the registration expires 21 September 2017. Food temperatures, including high risk items, are monitored appropriately and recorded</p>

		<p>as part of the plan. All staff who work in the kitchen have attended relative education and certificates were sighted.</p> <p>A nutritional assessment is undertaken for each individual resident on admission to the facility and a dietary profile is developed. The personal food preferences, any special diets and modified texture requirements are made known to the kitchen staff and accommodated in the daily menu plan. The daily meal plan is displayed in the dining room. Special equipment/resources, for example lipped plates, to meet resident's individual nutritional needs are available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys (last completed 26 May 2017) and residents' meeting minutes. Residents were seen to be given adequate time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find a more appropriate care alternative. If the needs of the resident change and they are no longer suitable for the services offered, a referral for a reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whānau. Examples of this occurring were discussed with the nurse manager, such as a resident requiring a secure dementia service or a dementia care service. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means 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 the three interRAI trained assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly documented, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families interviewed reported participation in the development and ongoing evaluation of the care plans.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with meeting their needs, goals and the plan of care. The attention to a diverse range of resident's individualised needs was evident in all areas of service provision. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' identified needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an experienced activities co-ordinator who has been in the role for two years.</p> <p>A social assessment and history is undertaken on admission to ascertain individual 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 evaluated six monthly as part of the six monthly care plan review.</p> <p>The planned monthly activities programme sighted clearly matches the skills, likes, dislikes and interests identified during the assessment process. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples include coffee club, exercise to music, general topic quiz and games, mind-games, chair bowls, entertainment and one-on-one activities, such as newspaper reading, nail cares, reading novels and/or just talking about the day. All residents receive a weekly activities programme and the programme is also displayed in various locations around the facility. Bus trips are held fortnightly and a contracted total mobility van is available. A market day was held at the facility during the audit and residents enjoyed participating for those that were able to do so.</p> <p>The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed that they find the programme fun, interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as a resident's needs change. The evaluations are recorded electronically by the registered nurse. Where progress is different from expected, the service responds by initiating changes to the care plan. Examples of short term care plans were consistently reviewed as required and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment</p>

		<p>process. Other plans, such as wound care and pressure injury plans, were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. The family communication record is also updated in the front of the resident's individual record.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The service has two general practitioners who cover this service. If the need for non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in the hard copy resident's records, including referrals to outpatient services at the DHB and/or in the community. Referrals are followed up as required by the GP. The resident and the family are kept well informed of the referral process, as verified in the documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to the nearest twenty four hour emergency centre in an ambulance if the circumstances dictate.</p>
<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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals had undertaken annual safe chemical handling education. 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/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness, expiry date 22 February 2018, is publicly displayed.</p> <p>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 (July 2017) and calibration of bio-medical equipment (April 2017) was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is</p>

		required, any requests are appropriately actioned and that they are happy with the environment.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All bedrooms have full ensuite facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are clearly identified visitor bathrooms and staff facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>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. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry which is well equipped. Laundry machinery is maintained six-monthly by an approved provider. Dedicated 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.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were</p>

<p>the setting in which the service is being provided.</p>		<p>stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by the chemical provider who undertakes six monthly monitoring checks and documents the findings.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe 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 27 February 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 8 June 2017. This identified that not all RNs, who are the nominated fire wardens, were fully aware of their duties in an emergency. This resulted in additional education being put in place to ensure they fully understood the required actions to take. This was confirmed in documentation sighted and during RN interviews.</p> <p>The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>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 47 residents. The emergency supplies are managed by the village staff (located in the same building but on a different level) and are clearly labelled. Emergency lighting is regularly tested.</p> <p>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.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff on duty check doors and windows.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and 19 of the 47 bedrooms have direct access to outdoor areas via a ranch-slider door. Underfloor electric thermostat control heating is provided in residents' rooms 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.</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>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. Infection control management is guided by a comprehensive and current infection control manual, developed with input from a quality management consultant. The infection control programme and manual are reviewed annually.</p> <p>The registered nurses sharing the role of infection prevention and control coordinator have their responsibilities defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and presented at the registered nurses meeting and at the quality meeting. The committee consists of the nurse manager and the two registered nurses.</p> <p>Signage is used in the lifts and at the main entrance to the facility requesting anyone who is, or has been unwell in the past 48 hours not to enter the facility. 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 related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</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>FA</p>	<p>The role of the infection prevention and control coordinator is shared between two registered nurses. Both registered nurses have the skill, knowledge and qualifications for the role. The two registered nurses have completed a post-graduate certificate in infection prevention and control. In addition to this, have completed the Ministry of Health (MoH) online infection control education.</p> <p>There are already well-established links with the DHB infection control team and expert advice can be sought from the GPs, the microbiologist from the community laboratory and the infection control specialists at the DHB if and when required. The registered nurses are able to access the residents' records and diagnostic results to ensure timely treatment and resolution of any infection.</p> <p>There are two infection prevention and control outbreak kits available and additional resources to support the programme and any outbreak of infection.</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</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed February 2017 and include appropriate referencing. Staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good handwashing technique and use of disposable aprons, gloves and hats, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at the time of orientation and ongoing education sessions. Education is provided by the two infection control coordinators. The content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of staff attendance is maintained. There has been no outbreak of infection since the last audit. The RNs interviewed stated that when an infection outbreak or an increase in infection incidence occurs, additional staff education would be provided. Education provided to residents is usually on a one-to-one basis and includes reminders about handwashing or staying in their own rooms if applicable.</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 infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, skin infections, gastro-intestinal, and upper and lower respiratory tract infections. When an infection is identified, a record is documented on the infection record sheet in the resident's individual records. The infection control coordinators review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Any new infections and any required management plans are discussed at handover, to ensure early intervention occurs. Results of the surveillance programme are shared with staff at the registered nurse meetings, staff meetings and at time of handover between shifts. Any trends identified are reported to the nurse manager. The service has provided assurance that infection rates in this facility are below average. Comparisons with previous months is summarised and reviewed annually when the programme objectives are set.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>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. The restraint coordinator (RN) provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and</p>

<p>minimised.</p>		<p>responsibilities. The facility is restraint free. Approved enablers are bedside loops, monkey bars and bedside rails.</p> <p>On the day of audit, no residents were using restraints and seven residents were using enablers, which were the least restrictive and used voluntarily at their request. Residents are assessed prior to enablers being used and consent forms were signed. During interview with two residents using enablers they confirmed the equipment being used allowed them to move around independently. (One bedside rail and one monkey bar). This was confirmed in the restraint register sighted.</p> <p>Restraint use is discouraged and during interviews with staff they were able to clearly describe the safe use of both enablers and restraint should it be required. Staff education occurs each year in October and during staff orientation as confirmed in documentation reviewed.</p>
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## 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.

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End of the report.