

Springvale Manor Limited - Springvale Manor Rest Home

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:

Legal entity:	Springvale Manor Limited
Premises audited:	Springvale Manor Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 28 August 2017 End date: 29 August 2017
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit: 14



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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

Springvale Manor Rest Home is privately owned and governed by three directors. Springvale Manor provides rest home and dementia level of care for up to 28 residents. On the day of audit there were 14 residents. The service is managed by an owner/manager who is supported by a part-time and full-time registered nurse. The residents and relatives interviewed spoke positively about the standard of care and support provided at Springvale Manor.

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

This certification audit identified areas for improvement around relative notifications, meeting minutes and registered nurse orientation.

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.		Some standards applicable to this service partially attained and of low risk.
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The staff at Springvale Manor ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The 2017 business plan has goals documented. There are policies and procedures to provide appropriate support and care to residents with rest home and dementia level needs. This includes a documented quality and risk management programme that includes analysis of data. Incidents are appropriately managed. Ongoing training is provided and there is a

training plan for 2017. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around clients' needs.

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 service has assessment processes and resident's needs are assessed prior to entry. There is an information pack available for residents and families/whānau at entry. Assessments, resident care plans, interventions and evaluations are completed by a registered nurse within the required timeframes. Risk assessment tools including interRAI assessments and monitoring forms were available and implemented. Care plans were individualised and identified involvement of allied health professionals.

A diversional therapist coordinates and implements a separate rest home and dementia unit activity programme that meets the abilities of all residents. The activities meet the individual recreational needs and preferences of the resident groups. There are integrated outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

All meals and baking is prepared and cooked on-site by qualified cooks. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks are available 24-hours.

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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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The buildings hold a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. There is a safe outdoor area and walking pathway within the secure unit. Resident bedrooms are personalised. Rest home rooms have an ensuite. There is access to an adequate number of communal toilet/shower facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme. There is at least one staff member on duty with a current first aid certificate.

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 service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit there were two residents with a restraint and no residents using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator/registered nurse is responsible for coordinating and providing education and training for all staff. The infection control manual outlines the scope of the programme and included a comprehensive range of policies and guidelines. There are infection control audits of the facility, hand hygiene competencies and surveillance of infection control events and infections.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	3	0	0	0
Criteria	0	98	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with five staff (two healthcare assistants (HCA), two registered nurses (RN) and one diversional therapist) confirmed their familiarity with the Code. Three rest home residents and four family members (two rest home and two dementia level care) interviewed, confirmed the services being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and	FA	There are established informed consent policies/procedures and advance directives. General consents were obtained on admission and sighted in six of six resident files reviewed (four dementia care including one younger person and two rest home residents including one resident under an intermediate care contract). Advance directives where appropriate, were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. The EPOA of three dementia care residents had been activated. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The two healthcare assistants (HCAs) and two registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.

give informed consent.		<p>Four family (two rest home and two dementia care relatives) confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>Long-term resident's files sampled had a signed admission agreement on file.</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>	FA	<p>Contact numbers for advocacy services are included in the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents and relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. The service has links to the local Alzheimer's Society, which provides support for those who have dementia or have a loved one with a diagnosis of dementia.</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>	FA	<p>Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community.</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>	FA	<p>The service has a complaints policy and procedures in place and residents and their family/whānau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The service had two complaints made in 2016 and no complaints received in 2017 year-to-date. Appropriate actions have been taken in the management and processing of the complaints. One of the complaints was made through the Health & Disability Commissioner (HDC) which was investigated and any corrective actions required were fully followed-up. A letter from HDC in 2017 confirmed that there would be no further action taken with the complaint. Residents and family members advised that they are aware of the complaints procedure and how to access complaint forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>The service provides information to residents that includes the Code, complaints and advocacy including in formats suitable for people with intellectual disabilities. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents interviewed identified they are informed about the Code. Surveys and direct communication with management provide the opportunity to raise concerns.</p>

<p>Consumers are informed of their rights.</p>		<p>Advocacy and the Code information is included in the information pack and are available at the service. The information pack also includes information about the dementia care unit, the need for a secure environment and behaviours that may be observed.</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>	<p>FA</p>	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend church services held within the facility or attend church services in the community if they wish. Residents interviewed reported that they can choose to engage in activities and access community resources and that their privacy is maintained. Staff attend education and training on abuse and neglect.</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>	<p>FA</p>	<p>The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the diverse cultural needs of residents and their whānau. Staff had training around cultural awareness in April 2017. The service has access to a cultural advisor from the local iwi health authority.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	<p>FA</p>	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Care plans sampled documented resident's individual needs.</p>

which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents who have been assessed as requiring rest home or dementia level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Combined quality/staff meetings are conducted monthly. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	There are appropriate policies and procedures to ensure that staff adequately communicate with residents and families. Incidents and accidents were reported and follow-up was completed by the RN. Family members interviewed confirmed that they are notified of any incidents however eight of the fifteen forms and corresponding resident files did not support that family had been notified of the resident's incident. However, fifteen incident forms reviewed showed that family notification is not always completed or a reason for this is not recorded. A quarterly newsletter is provided to residents and relatives. Residents interviewed stated that the owner/manager is on-site daily and visit residents to ask about their wellbeing. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of	FA	Springvale Manor Limited is the proprietor of Springvale Manor. Three directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. Springvale Manor provides rest home and dementia level care for up to 28 residents (eight rest home and 20 dementia beds). On the day of audit, there were 14 residents in total (four rest home residents including one resident under intermediate care contract and

<p>the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>ten residents in the secure dementia unit including one resident under 65 years of age).</p> <p>The owner/manager could describe the company's financial and business goals. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2017 business plan that outlines objectives for the period; a particular focus being increasing occupancy.</p> <p>The owner/manager (non-clinical) works full-time and has been in the position for eight and a half years. She is supported by a RN who works 32 hours per week and one other part-time RN who works eight hours per week or more as required. The owner/manager and RNs are also supported by a team of experienced care staff. A restructure of roles has meant there is no longer a clinical leader – instead there are 2 RNs. The manager employed an experienced RN in May 2017 to complete interRAI assessments, thus supporting the other RN to meet her responsibilities. The manager provides both RNs with support such as training.</p> <p>The owner/manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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 a temporary absence of the owner/manager, the RN provides oversight. The RN works 32 hours per week and provides on-call. The RN is supported by another RN and a team of experienced HCAs.</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</p>	<p>PA Low</p>	<p>Policies and procedures are developed by an external consultant and the manuals are updated when policies have been reviewed. Springvale Manor continues to implement an internal audit programme that includes clinical and non-clinical aspects of the services. The owner/manager facilitates the quality programme and ensures the internal audit schedules are followed. Corrective action plans are developed and signed off when service shortfalls are identified. Review of documents and staff interviews confirmed this. Discussions with the RNs, diversional therapist and HCAs confirmed their involvement in the quality programme. Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The staff meeting template includes headings relating to these items, however meeting minutes do not reflect that these have been routinely discussed and</p>

<p>continuous quality improvement principles.</p>		<p>communicated to staff.</p> <p>Resident and relatives survey was completed in July 2017 and shows satisfaction with services provided. Springvale Manor has a health and safety management system. There are risk management, health and safety policies and procedures including accident and hazard management.</p> <p>Falls prevention strategies are in place, which include the identification of interventions on a case-by-case basis to minimise future falls and staff received training to support falls prevention in August 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>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Fifteen incidents reviewed from June and July 2017 demonstrated clinical follow-up, however, not all family had been notified of the resident's incident (link 1.1.9.1). Neurological observations forms completed for resident falls with a head injury evidenced the required monitoring timeframes. The management team were aware of situations that require statutory reporting.</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>PA Low</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files sampled (two RNs, two HCAs and one cook) showed appropriate employment practices and documentation. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Current annual practising certificates are kept on file.</p> <p>The orientation package provides information and skills around working with residents with rest home and dementia level care needs, however, the two RNs have not completed the RN orientation since starting in November 2016. An annual training plan has been completed for 2016 and is in place for 2017. Training has been provided covering all the relevant mandatory training requirements.</p> <p>There are 11 HCAs that work in the dementia care unit; all 11 have completed the required dementia standards.</p> <p>Residents interviewed stated that care staff are knowledgeable and skilled.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/manager is on-site 32 hours per week. The owner/manager is on-call after hours for any non-clinical issues and the RN on-call for any clinical issues. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>There is an RN on-site on the morning shift from Tuesday to Saturday. There are two HCAs on the morning and afternoon shift and two on the night shift. There is an additional HCA (tea aid) on duty from 7.00pm to 9.00pm to assist with the evening meal and cover for staff meal breaks. Advised that extra staff can be called on for increased resident requirements.</p> <p>The four rest home residents are independent with most cares. Staff from the dementia unit check on them regularly as reported by staff and residents interviewed and call bells activate throughout the facility and can be heard by the staff in the dementia unit. These residents are invited into the dementia unit at times during the day to join activities and similar.</p>
<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>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Entries are legible, dated and signed by the relevant staff member including 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</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs including information on the dementia care service is provided for families and residents prior to or on admission. Prior to entry, all potential residents have a needs assessment, completed by the needs assessment and coordination service to assess suitability for entry to the service.</p>

been identified.		
<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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</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 practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The registered nurse and HCAs that administer medications have been assessed for competency on an annual basis. The full-time RN has completed syringe driver training. Education around safe medication administration has been provided. Medications are checked on delivery by the RN. There were no standing orders in place. There was one rest home resident self-medicating on the day of audit who had self-medication competency in place. All medications are stored safely.</p> <p>All 12 medication charts reviewed (four rest home and eight dementia care) on the electronic medication system met legislative prescribing requirements. The GP has reviewed the medication charts three-monthly. Medication administration records sighted on the electronic medication system corresponded with the medication charts.</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>	FA	<p>All meals and home baking is prepared and cooked on-site. The qualified cook on duty is supported by a weekend cook and tea aide. Food services staff have completed food safety hygiene training. There is a four-weekly menu that has been reviewed by a dietitian. The kitchen is located within the dementia unit adjacent to the dining room. Meals are served to rest home residents in a separate dining room within the rest home. The cook receives resident dietary instructions that includes resident dislikes and special requirements. Dislikes are accommodated. The cook is notified of any changes to residents' dietary needs or residents with any weight loss. Modified diets and diabetic desserts are provided. There is specialised crockery and utensils as assessed. Nutritious snacks are available at all times from the kitchen and include sandwiches, biscuits, puddings, yoghurts and fruit.</p> <p>Kitchen fridges and freezer temperatures are monitored twice daily and recorded. End cooked food temperatures on all meals are monitored and recorded daily. All goods in the pantry were date labelled. All perishable foods in fridges were date labelled. Staff were observed wearing personal protective clothing. Cleaning schedules are maintained.</p>

		Rest home residents and relatives interviewed commented positively on the meals provided.
<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	The admission policy describes the declined entry to services process. Springvale Manor records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau and refers the resident/family/whānau back to the referral agency.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for all long-term resident files sampled. The long-term care plans in place reflected the outcome of the assessments. Behaviour assessment tools had been completed in the files of dementia care residents.
<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>Resident care plans reviewed were resident focused and individualised. All identified support needs as assessed were included in the care plans for all long-term resident files reviewed. A short-term care plan was in place for the interim care resident which addressed all identified needs. The three files of residents in the dementia care unit contained a comprehensive behaviour management plan including triggers, de-escalation techniques and activities. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration and evidence of allied healthcare professionals involved in the care of the resident.</p> <p>Short-term care plans were in place for short-term needs. Short-term care plans had been reviewed regularly and either resolved or transferred to the long-term care plan if an ongoing problem.</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>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There was evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the relative record page.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for two skin tears and one chronic ulcer. There were no pressure injuries on the day of audit. There was a range of equipment readily available to minimise pressure injury.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p> <p>Monitoring occurs for weight, observations, blood glucose, pain, challenging behaviour, wounds and continence. Registered nurses review the monitoring charts and report identified concerns to the GP.</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 service employs a qualified and registered diversional therapist (DT) for 36 hours Monday to Friday. The DT is involved in the education of the regional DT support group. She has a current first aid certificate and is completing the master class of "walking in another's shoes". Healthcare assistants are involved in providing activities a part of their role. The DT provides a programme that is flexible to meet the needs of the dementia care residents and the rest home residents. Consent is gained from rest home residents and their families to join some activities in the dementia unit such as entertainment, church services, board games, guest speakers and outings. There is a large double lounge that can be closed off from the dementia unit (if required) to provide an entertainment area. Daily contact is made with rest home residents and their recreational preferences for the day identified and met. One-on-one time with residents includes foot care, nail care, walks, arts and crafts. A sensory room in the dementia unit provides a low stimulus environment with soothing music and low lighting, which reduces resident agitation and decreases episodes of challenging behaviours. Small group activities include exercises, board games, ladies group and card groups. The service hires a van and outings include community visits to local clubs and the RSA. Families are invited to attend outings with their relative. One-on-one time is spent with the younger person on preferred activities such as arts and crafts/painting. The younger person is supported to attend community activities including housie, bowls and special Olympics.</p> <p>Activity assessments are completed soon after admission. Each resident had an individual activity plan which is reviewed six-monthly.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three-monthly or earlier if required. The relative/resident are invited to attend the multidisciplinary team review. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</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>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p> <p>On the day of audit all residents were appropriately assessed as rest home level care and none were waiting for reassessment.</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</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets are readily accessible for staff. Chemicals sighted have correct manufacturer labels. Chemicals are stored in locked areas (sluice room and laundry). Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have attended chemical safety training.</p>

during service delivery.		
<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>Springvale Manor rest home building has a current building warrant of fitness that expires 22 June 2018.</p> <p>The building has two entrances, one at the rest home and one at the dementia care unit with secure access to the unit.</p> <p>Hallways in both the rest home and the dementia care unit are sufficiently wide enough to allow residents to mobilise with the aid of walking frames and other mobility aids safely. There has been ongoing refurbishment of resident rooms, painting of ceiling in the dementia unit and upgrading of the outdoor dementia garden and grounds.</p> <p>The owner/manager contracts a mobile maintenance person for repairs and planned maintenance as per the schedule. The maintenance log book (sighted) evidenced repairs are carried out within a timely manner. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated annually. Planned maintenance includes hot water temperature monitoring monthly, carried out by the plumber.</p> <p>The rest home residents have safe access to outdoor areas where seating and shade is provided.</p> <p>The dementia care unit has four exit and entry points to the safe and secure outdoor walking pathway and garden areas, which provide seating and shade.</p> <p>The RN and HCAs (interviewed) stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. A hoist is available if required post falls.</p>
<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</p>	FA	<p>The four double rest home rooms have a full ensuite. There is a communal toilet off the rest home lounge with privacy locks. There are sufficient numbers of communal toilets/showers in the dementia unit. Toilet and shower facilities are of an appropriate design to meet the needs of the residents.</p>

requirements.		
<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>There are four double rest home rooms. All have single occupancy. There is provision for privacy curtains. All resident rooms in the dementia unit are single. There is adequate room to safely manoeuvre with mobility aids in the resident bedrooms. Residents and families are encouraged to personalise their rooms as evident on audit day.</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>The rest home has a separate TV lounge and a separate dining room with doors that open out onto the outdoor courtyard and gardens.</p> <p>The dementia unit has a double lounge which can be closed into two smaller lounges while maintaining safety for dementia care residents. There is a smaller quieter lounge at the other end of the unit. There is a separate dining room for dementia care residents adjacent to the kitchen. The kitchen has safety gates in place.</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 the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry is located within the dementia unit with keypad access and a locked external screen door. There is a defined clean/dirty flow. There is a dedicated laundry person Monday to Friday. All personal clothing and linen is laundered on-site. All equipment has a service check and is tested and tagged.</p> <p>There is a cleaner's room where the trolley is stored when not in use. There is a dedicated cleaner Monday to Friday. The HCAs complete basic laundry and cleaning duties in the weekend. The contracted chemical supplier monitors the effectiveness of the cleaning and laundry processes.</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>Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation plan. Fire drills are held six-monthly with the last drill occurring on 20 April 2017. There are sufficient staff with current first aid certificates to cover every shift. There is a civil defence kit that is checked six-monthly. The kitchen has gas hobs and there is a BBQ for alternate cooking. There is sufficient stored water and food supplies to last three days. If required the facility would hire a generator. There is an appropriate call bell system that works throughout the facility. There are keypads on appropriate doors in the dementia unit. In the rest home, external doors are kept locked after dusk.</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>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and opening windows for ventilation. All bedrooms have good sized windows which allow plenty of natural light.</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 infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control team. The RN is the infection control coordinator and has been in the role 10 months. The infection control programme is linked into the quality management system and reviewed annually last in April 2017 by the infection control coordinator and owner/manager.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents. Hand sanitisers are available throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control</p>	<p>FA</p>	<p>The infection control coordinator is registered to attend an infection control conference in October. The service is affiliated with an external aged care consultant for any advice or updates for policies. The facility has access to an infection control nurse specialist at the DHB, wound care nurse, public health, laboratory and GPs. The part-time</p>

<p>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>RN is a member of the infection control nurses group and receives updates on infection control practice.</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 comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff,</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the annual training programme last provided in June 2017. Staff are required to complete infection control questionnaires. Handwashing competencies were completed May 2017.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>

and consumers.		
<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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections. Infection control data and relevant information is reported to be discussed but not evidenced in meeting minutes (link 1.2.3). Definitions of infections are in place appropriate to the complexity of service provided. Internal audits for infection control are included in the annual audit schedule</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit there were two residents with a restraint (one lap belt and one chair brief) and no residents using an enabler. Both residents using restraint were dementia level care and the use of restraint was only 'as required' to keep residents' safe from falls. Strategies uses to minimise use of restraint included sensor mats, early recognition of infections (UTI/chest), confusion and delirium, GP visits, distraction with activities and staff supervision. Staff training is in place around restraint minimisation and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. An RN is the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau were evident. Two resident files where restraint was in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions trialled before implementing restraint. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Monitoring is documented on a specific restraint monitoring form, evidenced in the two resident files where restraint was being used. A restraint register is in place providing a record of restraint and enabler use.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed at the monthly staff/quality meeting. A review of the two resident files identified that evaluations are up-to-date.
<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>	FA	Staff/quality meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education/training.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	There are appropriate policies and procedures to ensure that staff adequately communicate with residents and families. Incidents and accidents were reported and follow-up was completed by the RN. Fifteen incident forms reviewed showed that family notification is not always completed or a reason for this is not recorded.	Fifteen incident and accident forms were reviewed. Eight of the fifteen forms and corresponding resident files did not document that family had been notified of the resident's incident.	Ensure that family is notified of incidents and accidents in a timely manner. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate,	PA Low	Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The staff meeting template includes headings relating to these items, however meeting minutes do not reflect that these have been routinely discussed and communicated to staff.	There was no documented evidence in meeting minutes that meetings included discussion around quality data trends analysis and what actions were required by staff.	Ensure that staff meetings include discussion of quality data trends analysis and actions

consumers.				required, if any. 90 days
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	The orientation package provides information and skills around working with residents with rest home and dementia level care needs, however, the two RNs have not completed the RN orientation since starting in November 2016.	The two RNs employed since November 2016 have not completed the required RN orientation.	<p>Ensure that the two RNs complete the RN orientation.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.