

Mateus Enterprises Limited - Seaview Home

Introduction

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

The audit has been conducted by HealthShare 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: Mateus Enterprises Limited

Premises audited: Seaview Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 17 October 2017 End date: 17 October 2017

Proposed changes to current services (if any): There are no proposed changes to the current service.

Total beds occupied across all premises included in the audit on the first day of the audit: 27

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

| Indicator | Description | Definition |
|-----------|--|---|
| 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

Seaview Home provides rest home level care for up to 28 residents. The service is owned and governed by Mateus Enterprises Ltd.

This unannounced surveillance audit was conducted against a sub set of 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, relatives, management, staff and a general practitioner.

This audit has resulted in four areas requiring improvement.

All previously required improvements have been addressed.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Residents are aware of their rights including the right to make a complaint and the right to full and frank information.

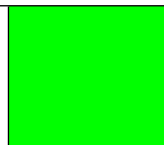
Organisational management

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| 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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There is a documented and implemented quality and risk management programme to which service delivery is well linked. One of the directors is responsible for maintenance and the other is the clinical and operations manager with infection control responsibilities. The clinical/operations manager is supported by twenty employees including a registered nurse who has undertaken orientation and participated in ongoing training. Professional qualifications have been validated and recorded. Incidents, adverse events and complaints are managed and reported. Incident forms are completed. Resident information is integrated.

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.

Care plans and assessments reviewed are completed by nursing staff within the required time frames and demonstrate service integration. Long term care plans are reviewed every six months and short term care plans are consistently developed when acute conditions are identified.

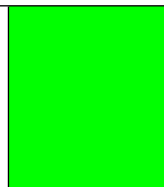
Planned activities are appropriate to the resident's needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

The meal service meets the individual food, fluids and nutritional needs of the residents. Residents with special dietary needs are catered for.

A safe medication management system is in place and medication is administered by staff with current medication competencies. All medications charts are reviewed by the GP every three months or as required.

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.

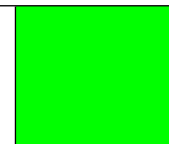


Standards applicable to this service fully attained.

There have been no changes to the facility since the last audit. There is a current BWOF and approved fire evacuation plan

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.

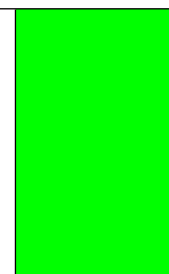


Standards applicable to this service fully attained.

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme is appropriate to the size, type and risk of a 28 bed rest home. Surveillance is undertaken and there is evidence of a reduction in the number of one of the targeted surveillance infections in the past twelve months.

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 | 15 | 0 | 2 | 0 | 0 | 0 |
| Criteria | 0 | 37 | 0 | 4 | 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 |
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| <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>There is a documented procedure for reporting and managing complaints which is readily available to residents / families and staff. The procedure complies with Right 10 of the Code. There is a complaints register which is completed and is current and includes dates of complaints, correspondence and follow up. In interviews, residents and staff demonstrated there is a good understanding of the residents' right to complain and for their complaint to be respected. There have been no complaints to external authorities since the last audit.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p> | FA | <p>Family/whanau are notified of any adverse, unplanned or untoward events and this is recorded on incident forms sighted in resident files reviewed. Staff education has been provided related to appropriate communication methods. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Family/whanau reported they are informed of any events or concerns.</p> |

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| communication. | | |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The Directors have job descriptions, and have developed a strategic plan which includes a philosophy, values and objectives. This is monitored and formally reviewed every three years and the objectives are appropriate to the needs of the residents and the business. The plan is available to all staff.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | PA Low | <p>There is a current documented quality and risk management programme which includes a document control system and aligns with current good practice and legislative requirements including Health and Safety at Work Act 2015, the Code of Disability Rights and the Ministry of Health Guidelines for pressure injury recording and reporting. Internal audits and monitoring are planned and staff have access to the quality programme. The quality plan has been reviewed June 2017. Staff who were interviewed were able to demonstrate their understanding of the programme and related procedures. Staff / management / quality meeting minutes demonstrate communication about the system. Service delivery is linked to the quality management system evidenced by sighting comprehensive resident satisfaction surveys and minutes of staff meetings demonstrating satisfaction with the service provided.</p> <p>There is a risk management plan; however risk has not been assessed using the severity rating scale (as required in policy) and an improvement is required. Improvements are also required regarding the collation and analysis of quality related data and the follow up of corrective actions.</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</p> | FA | <p>The incident and accidents policy and procedure include major incidents and reporting requirements. Management and staff interviews confirmed their understanding of essential notification reporting. There has been no essential reporting in the past twelve months. The system was verified by sighting three completed incident forms for this year and confirmed these forms are completed in full and the outstanding required improvement has been addressed.</p> |

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| choice in an open manner. | | |
| <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> | PA Low | <p>Recruitment, reference and criminal vetting checks and validation of professional qualifications are part of the recruitment procedure and align with good employment practice. Orientation is completed and records sighted confirm it is suitable to the service provided and the contract for service. There are two people who are designated to drive the van and both these people have a copy of their current drivers' licences on file. Training is planned annually. Staff interviews and review of their records confirmed additional and relevant and mandatory training is provided including use of the InteRAI system and performance reviews are conducted and recorded.</p> <p>An improvement is required regarding completion of food safety training for the cook.</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> | FA | <p>Service providers include registered nurses, rest home carers, general practitioners and other health professionals. The roster is used to identify numbers and skills mix of staff. There is a registered nurse on duty 5 days/week and a registered nurse on call for other days and over-night. General practitioners and other health practitioners are readily accessed.</p> <p>It is documented that should the resident numbers fall to less than 20 the roster is to be reviewed. All rostered staff are employees. At least one staff member on duty has a current first aid certificate (refer 1.4.7) which demonstrates the required improved from the previous audit has been addressed.</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>The medication management system complies with legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. All medications are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are clearly documented, photos are current and three monthly reviews are done. Medication charts are legibly written.</p> <p>The medication and associated documentation are stored safely and medication reconciliation is conducted by the RN when a resident is transferred back to service. The service uses pre-packaged packs. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. The controlled drug register is current and correct. Weekly and six monthly stock takes are conducted.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RN was observed administering medications safely and correctly.</p> <p>The previous improvements have all been addressed. All medications are prescribed correctly, dated as per policy</p> |

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| | | <p>guidelines and over the counter remedies are indicated in the medication charts. Residents who self-administered their medications such as inhalers and creams are assessed as competent and medications are stored in a secure safe place. Self-administration policies and procedures are in place. Administration charts have also been maintained as required.</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>Meal services are prepared on site and served in the allocated dining room. The service employs a cook who works from Monday to Friday. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four weekly rotating winter and summer meal in place.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the service. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The resident's weights are monitored monthly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is done.</p> <p>The residents and family interviewed acknowledged satisfaction with the food service. The satisfaction survey indicated that residents are happy with the service.. The cook had no food safety training (refer to 1.2.7.3).</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 are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. The previous improvement has been addressed. All care plans sampled included detailed interventions to meet the resident's current health status.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p> | FA | <p>The documented interventions in short term care plans and long-term care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Any changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving. Short</p> |

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| order to meet their assessed needs and desired outcomes. | | term care plans had required interventions to address any short term problems identified and this corrective action from the previous audit was actioned in care plans sampled. |
| <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> | FA | Activities are appropriate to the needs, age and culture of the residents. The activities coordinator develops an activity planner and daily/weekly activities are posted on the notice boards. Resident's files have a documented activity plan that reflects the resident's preferred activities of choice. Over the course of the audit residents were observed being actively involved with a variety of activities and residents interviewed expressed satisfaction with the activities in place. Individualised activity plans are reviewed six monthly or when there is any significant change in participation and this is done in consultation with the RN. The activities vary from scrabble, bingo, music, van trips, exercises/walking and church services. The activities coordinator reported that they have group activities and also engage in one on one activities with some residents. Activities are modified to varying abilities and cognitive impairment. The resident's activities participation log was sighted. |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | Residents long term care plans and activity plans are evaluated in a comprehensive and timely manner. Reviews are fully documented and include current resident's status, any changes and achievements towards goals. Family/whanau, staff input is sought in all aspects of care and are reviewed/evaluated. Short term care plans are developed as per rising need. The previous improvement has been addressed. All care plans sampled were updated and reviewed every six months or as required. |
| <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 | There have been no changes to the facility since the last audit. There is a current BWOFF and approved fire evacuation plan. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p> | FA | A surveillance programme has been implemented and has demonstrated a reduction in a target surveillance infection in the previous twelve months. Actions taken by staff have directly impacted on this improvement. Infection surveillance practice, activities and outcomes are well documented and supported with evidence of compliance sighted. The clinical manager oversees the programme and staff are informed of surveillance |

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| <p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | | <p>outcomes. There have been no identified outbreaks for 2017.</p> |
| <p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Seaview Home has a commitment to providing quality services for residents in a safe environment and work to minimise the use of restraint. All staff receive education regarding restraint minimisation and management of challenging behaviours. Staff interviewed were clear regarding the difference between a restraint and enabler use. The service currently has no residents using restraint or enablers. A restraint register was sighted.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|-------------------|---|--|---|
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | PA Low | Data is collected monthly for example incidents / accidents / falls / infections / complaints and these are discussed at staff/management/quality meetings. The data has not been evaluated and analysed. | Collected quality improvement data is not analysed and evaluated for trending purposes as per standard and policy. | <p>Analyse and evaluate quality data annually to identify opportunities for improvement.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or</p> | PA Low | Although there is evidence that actions have occurred post incident / internal audit there is no documented procedure or | Although there is evidence that actions have | Update the Quality and Risk |

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| requirements is developed and implemented. | | evidence of corrective action planning and follow up. | occurred post incident / internal audit there is no documented procedure or evidence of corrective action planning and follow up. | Management Programme to include corrective action planning and follow up to guide staff in its application. 90 days |
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p> | PA Low | There is a risk management plan that is incorporated into the current strategic plan. Risks have been identified but not fully rated for example impact and likelihood have been documented but final severity rate has not. There is a register of hazards last reviewed August 2017 however the hazards have not been risk assessed. | Risks have not been fully assessed using the risk analysis rating scale (as required in policy). | Update the current risk management plan to include severity ratings and Health and Safety risk register. 90 days |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | Staff are appointed to safely meet the needs of the residents and the organisation including interview, reference checks, criminal vetting and orientation. Sighted staff files and verified the requirements have been met. There are two people who are designated to drive the van and both these people have a copy of their current drivers' licences on file, however the cook on duty during the audit had no food safety | The cook on duty during the audit had no record of completing food safety training. | Ensure the cook completes food safety training. 90 days |

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| | | training recorded. | | |
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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.

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| No data to display |
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End of the report.