

Tony And Cora Noblejas Limited - Christina's Rest 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 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:

Legal entity: Tony and Cora Noblejas Limited

Premises audited: Christina's Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 6 October 2017 End date: 6 October 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 17

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 |
|-----------|--|---|
| | 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

Christina's Rest Home provides rest home and hospital level care for up to 21 residents. The service is operated privately by the owner/manager who is a registered nurse. They have owned and operated the service for the past 27 years. Residents and families spoke positively about the care provided.

This surveillance 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, the owner/manager, staff, and a general practitioner.

This audit has resulted in no areas identified for improvement. There were no areas identified for improvement at the previous audit.

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

A complaints register is maintained with complaints resolved promptly and effectively.

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. |  | Standards applicable to this service fully attained. |
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Business and quality and risk management plans and objectives include the scope, direction, goals and values of the organisation. Monitoring of the services provided is undertaken by the owner/manager on a regular basis.

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 developed by an off-site organisation are personalised to Christina's Rest Home to support service delivery. They were current and have been 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 and contractual requirements.

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.



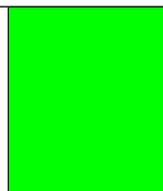
Standards applicable to this service fully attained.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. The nurse manager works Monday to Friday and is on call 24 hours each day. The nurse manager is supported by care staff and allied health staff and a designated contracted general practitioner. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on an integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' records reviewed demonstrated that needs, goals, interventions and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

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 is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

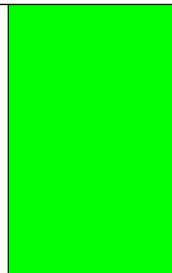


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that supports a restraint free environment. No enablers and no restraints are in use at the time of audit. An assessment, approval and monitoring process is identified in policy should restraint be required. Policy states that the 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 approval process and the management of challenging behaviour without the need for restraint.

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.

Aged specific infection surveillance is undertaken, analysed, trended and results are reported through all levels of the organisation. Follow-up action is taken as and when required. The surveillance programme for this rest home is appropriate for the size and nature of services provided.

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 | 16 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 39 | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| 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> | <p>FA</p> | <p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that no complaints have been received over the past year. Minor concerns, such as food dislikes, are recorded in a concerns register and it showed that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The owner/manager is responsible for complaints management and follow up.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p> | <p>FA</p> | <p>Residents and family members stated they were kept well informed about any changes to their/their relative`s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the residents` records reviewed. There is also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.</p> |

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| <p>provide an environment conducive to effective communication.</p> | | <p>Interpreter services are able to be accessed via the CMDHB when required. Staff knew how to do so if needed, although this was rarely required due to staff who are able to provide interpretation as and when needed and the use of family members, as appropriate.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The quality and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual objectives and the associated operational plans. A sample of monthly reporting against organisational goals and an annual review of all quality data undertaken by the owner/manager showed adequate information to monitor performance. This included quality data, occupancy, staffing, emerging risks and issues.</p> <p>The service is managed by the owner who is a registered nurse and has been in the role for 27 years. She attends regular clinical and non-clinical education/training sessions both on and off site. The owner/manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at appropriate District Health Board workshops and via age care organisations' educational sessions.</p> <p>The service holds contracts with Counties Manukau District Health Board (CMDHB) and the Ministry of Health (MoH) for Residential Non-Aged Care. Sixteen residents were receiving services under the CMDHB Age Related Residential Care contract and one resident was under the MOH contract at the time of audit. The CMDHB also place residents in the facility under the Primary Options for Acute Care (POAC) contract at times during the year, but there were no residents under this contract at the time of audit.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>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, and clinical incidents including infections, falls, challenging behaviour and wounds.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. The owner/manager reviews all monthly quality data and trends it against previously collected data. Full annual reviews at governance level are clearly documented.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (September 2017) showed that families and residents are satisfied with the services offered. The only negative comment sighted from one resident was related to meals not always being 'tasty'. This was followed up using the minor concerns process. The owner/manager discussed the resident's meal preference with the resident and</p> |

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| | | <p>gained a positive outcome.</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 developed by an off-site organisation and are personalised to Christina's Rest Home. They 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 owner/manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Staff confirmed during interview that any new hazard is reported using a specific form which also identifies the actions taken to mitigate the risk. The hazard register covers care and overall services, external risks, cleaning and laundry and the kitchen. This is reviewed by the owner/manager in June each year.</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>Staff document adverse and near miss events on an accident/incident form. All seven incident and accident forms for 2017 were reviewed. They showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. There were no incidents or accidents for the months of February, April or June of 2017. Adverse event data is collated, analysed and reported to the owner/manager. Staff confirmed a very low incident and accident rate and that they document all events. They feel it is very low owing to the residents being rest home level care and mostly independent with their mobility.</p> <p>The owner/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. Nor have there been any police investigations, coroner's inquests, issues based audits and any other notifications, such as public health.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>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 five 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 show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on a bi-annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the</p> |

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| | | <p>requirements of the provider's agreement with the DHB. The owner/manager confirmed all caregivers are at least level two with one caregiver holding level four status. Staff reported during interview that they have sufficient and appropriate training for the roles they undertake.</p> <p>The owner/manager holds a current nursing practising certificate and is trained and maintains her annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The staffing level of experience and education meets the requirements of the DHB contractual requirements. The owner/manager is on call afterhours, 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 four-week roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. (Staff replacement is shown in the owner/manager's diary). At least one staff member on duty has a current first aid certificate.</p> <p>There are dedicated cleaning staff six days a week. A gardener is contracted for a minimum of eight hours per week. Caregivers undertake laundry duties as part of their daily schedules.</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 policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All senior care staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packed format from a contracted pharmacy. These medications are checked by the nurse manager against the prescription when delivered from the pharmacy. All medications sighted were within current use by dates. Legislative requirements are met. There is no designated medication room due to the size of this facility. A small locked cupboard is available in the locked nurse office. A medication trolley is available and this is locked when not in use.</p> <p>The records of temperatures for the medicine fridge were within the normal recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date being recorded on the</p> |

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| | | <p>commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines being met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if needed.</p> <p>Medication errors are reported to the nurse manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for analysis of any medication errors, and compliance with this process was verified. There were no standing orders observed.</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>The foodservice is provided on site by staff. Meals are prepared in line with recognised nutritional guidelines for older people. The menu audit occurred 04 July 2017. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Any recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The staff have completed hand hygiene training. The nurse manager is responsible for all food prepared in the kitchen, purchasing special equipment if required and managing the staff who work in the kitchen. The care staff have completed relevant food handling training.</p> <p>A nutritional assessment is undertaken for each 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 know to the kitchen staff and accommodated in the daily menu plan. Special equipment to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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> | FA | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting the diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range off equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |

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| <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 a senior caregiver who maintains the programme. A social/personal history and interests assessment is completed on admission to ascertain residents` needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident`s activity needs are evaluated six monthly and as part of the formal six monthly care plan review and interRAI reassessment.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents` goals, ordinary patterns of life and includes normal community activities. Individual or group activities and regular events are offered. All staff assist with the programme. The programme includes bingo, music sessions, cultural events, entertainment and other activities. The residents` meetings are held two monthly and an advocate visits six monthly. The activities programme is discussed at the resident`s meeting and the minutes reviewed indicated that the residents` input was 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 enjoyed the programme.</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 records. If any change is noted, it is reported to the nurse manager.</p> <p>Formal care plan evaluation, occur every six months in conjunction with the six monthly interRAI reassessment or as residents` needs change. Evaluations are documented by the nurse manager. Where different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for wound care and weight loss and progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Resident and families interviewed provided examples of involvement with evaluation of progress and any resulting changes.</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> | <p>FA</p> | <p>A current building warrant of fitness (expiry date 16 March 2018) is publicly displayed. The facility footprint has not changed since the previous audit.</p> |

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| <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> | <p>FA</p> | <p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record is documented on the infection reporting form. The nurse manager reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and any required actions. Results of surveillance are shared with staff via the staff meetings as confirmed by sighting the minutes of the meetings held and at handover between shifts. Graphs are produced to identify any trends and compared against the previous month. Data and audit results were compared annually.</p> <p>No outbreaks have been reported. Residents sign a consent form for any vaccinations such as the influenza vaccinations administered annually. No vaccines are stored on site.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <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 should they be required. The owner/manager is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility as required. She demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Christina's operates a restraint free environment.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. This was confirmed in the meeting minutes sighted and in the annual review of quality data. Policy states that enablers will be the least restrictive and used voluntarily at their request.</p> <p>Staff confirmed their knowledge and understanding of managing challenging behaviour without the use of restraint. (Education occurred in February 2017).</p> <p>There is an electronic gate into the car park but the walking gate is not locked and residents are free to leave the premises as they choose.</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.

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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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End of the report.