

# CSR Healthcare Limited - Heritage Remuera Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	CSR Healthcare Limited
<b>Premises audited:</b>	Remuera Rest Home and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 2 October 2017 End date: 3 October 2017
<b>Proposed changes to current services (if any):</b>	This audit has assessed the service as suitable to provide hospital (medical) level of care.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	33

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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

Remuera Rest Home and Hospital provides rest home and hospital (geriatric) levels of care for up to 35 residents. On the day of the audit there were 33 residents and one independent boarder that receives hospitality services but not care.

This audit included assessing the services suitability to provide hospital (medical) services. A review of the environment, staffing and staff training, policies, equipment available, access to external support and the organisational management system demonstrated the service is suitable and able to provide hospital (medical) level of care.

This certification audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The facility manager is a registered nurse. He is appropriately qualified and experienced and is supported by a team of experienced staff. There are quality systems being implemented. Feedback from residents and families was very positive about the care and services provided.

This certification audit identified that improvements are required in relation to hot water temperatures and the smoking area.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Māori values and beliefs are understood and respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community.

Complaints processes are implemented, and complaints and concerns are managed appropriately.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The manager is a registered nurse (RN) who is on-site five days a week and is on call when not on-site. He is supported by a team of RNs, including two designated clinical leaders.

There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Registered nurses are responsible for the provision of care and documentation at each stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. The individualised care plans are goal orientated, and reviewed every six months or earlier if required. There is input from resident/family as appropriate. Allied health and a team approach are evident in the residents' files reviewed. The general practitioner reviews residents three monthly and as needed.

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

Medications are managed appropriately in line with accepted guidelines. The registered nurses and healthcare assistants who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness. Maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy, and all but two rooms have shared ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounges and a dining area in the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster including an approved emergency 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.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. During the audit there was one resident using restraint. No enablers were in use.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	49	0	1	0	0	0
<b>Criteria</b>	0	99	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policy relating to the Code is implemented. The facility manager/registered nurse (RN) and six care staff interviewed (three RNs including two clinical leaders, two healthcare assistants and one recreational officer) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files sampled (three hospital and three rest home) demonstrated that advanced directives are appropriately signed for. There is evidence of discussion with family when the GP has completed a clinically indicated 'not for resuscitation' order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had an admission agreement signed on or before the day of admission and consent forms signed.</p>

<p><b>Standard 1.1.11: Advocacy And Support</b></p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Health and Disability Commissioner (HDC) advocacy details are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p><b>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</b></p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p> <p>Community links are established with local community groups. For example, three residents are taken to a Communicare group meeting on Tuesdays, one respite resident was observed leaving to attend a craft group, residents attend church services, and residents attend the local pool. One resident attends ballroom dancing on the weekends. Residents are able to come and go from the facility as they please. Residents who are able, regularly visit the local cafes and shops.</p>
<p><b>Standard 1.1.13: Complaints Management</b></p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>A record of complaints received is maintained by the facility manager. Five complaints have been lodged in 2017 (year-to-date) and were reviewed. Complaints are being managed in accordance with HDC guidelines. One complaint was lodged through the DHB around the care of one resident. An action plan has been developed, which includes providing residents with a designated outdoor smoking area (link 1.4.2.6). The facility manager has met with the DHB and the complaint is documented as resolved.</p> <p>Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p><b>Standard 1.1.2: Consumer Rights During Service Delivery</b></p>	FA	<p>Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to new residents and their families. The facility manager or a clinical leader discusses</p>

<p>Consumers are informed of their rights.</p>		<p>aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the two-monthly residents' meetings. All seven residents (four hospital and three rest home including one resident on the younger person with a disability (YPD) contract) and three family (two rest home, one hospital) interviewed, reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The residents' personal belongings are used to decorate their rooms. The healthcare assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Shared toilets include appropriate door locking mechanisms.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins during their induction to the service. This training is repeated annually.</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>A Māori health policy is documented for the service. Links are established with a Kaumātua from the Greenlane Clinical Centre. Rooms are blessed by the Mercy Hospice nuns following the death of a resident. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. There was one resident living at the facility who identified as Māori. A Māori health plan had been developed for this resident. Also included in this resident's file was information relating to their iwi.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as an annual training topic.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all six care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The facility manager/registered nurse is on-site five days a week and is supported by a team of RNs, including two clinical leaders. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Resident meetings are held two-monthly. Residents and family/whānau interviewed reported that they are very satisfied with the services received. This was also confirmed in the 2017 resident/family satisfaction survey.</p> <p>The service receives support from the district health board (DHB). Physiotherapy services are provided as needed. A van is available for regular outings. A podiatrist visits the facility every six weeks. Mental health services through the DHB were observed visiting residents during the audit.</p> <p>The environment allows for close relationships between the staff and residents. A recreational officer is on-site four days a week. Healthcare assistants and volunteers assist with activities in the absence of the recreational officer.</p> <p>Service specific improvements have included the implementation of a resident-centred care plan that reflects a rating of continuous improvement.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Twenty accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. There were five residents at the facility who were unable to speak or understand English. Families and staff are utilised in the first instance with Mandarin speaking staff available on all three shifts, seven days a</p>

		week.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Remuera Rest Home and Hospital provides rest home and hospital (geriatric) levels of care for up to 35 residents. Fifteen rooms are designated for rest home level of care and twenty rooms are designated as dual-purpose (hospital/rest home). On the day of the audit there were 33 residents (20 rest home and 14 hospital). This included nine residents on a long-term chronic condition contract (four rest home and five hospital), two residents on respite (rest home) and two residents on the young persons with disabilities (YPD) contract (rest home). The was currently one independent boarder residing at the facility.</p> <p>This audit has assessed the service as suitable to provide hospital (medical) level of care.</p> <p>A philosophy, mission, vision and values are in place. The business plan (2017 – 2018) is regularly reviewed by the manager and the owner of the facility. The facility manager reports that he meets regularly (as frequently as daily) with the owner.</p> <p>The facility manager is an RN who has been in his role for four years and has nine years of management experience in the aged care sector. He has maintained a minimum of eight hours of professional development per year relating to the management of an aged care facility.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	FA	<p>There are two clinical leaders/RNs who are responsible for clinical operations in the absence of the facility manager. The owner assumes administrative responsibilities in the absence of the facility manager.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	FA	<p>A quality and risk management system is understood and being implemented as confirmed during interviews with the facility manager and eight staff (six care staff, one maintenance officer/cleaner, one chef).</p> <p>Policies and procedures align with current good practice and meet legislative requirements. Policies have been reviewed, modified (where appropriate) and implemented. Reviews take place two yearly or when policies are updated. A document review schedule is in place. New policies are discussed with</p>

<p>continuous quality improvement principles.</p>		<p>staff. This is a regular agenda item in staff meetings. Staff are asked to sign that they have read new/revised policies (eg, skin and pressure risk prevention and management policy).</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Quality data and outcomes are discussed with staff in the monthly staff meetings. Where improvements are identified, corrective actions are documented, implemented and signed off by the facility manager, however, no corrective actions were in place for hot water monitoring (link 1.4.2.4).</p> <p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Interviews were conducted with the health and safety officer who is the facility manager. Staff health and safety training begins during their induction to the service. Health and safety is a regular topic covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, intentional rounding with two-hourly checks, and challenging behaviour plans.</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>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurologic observations are conducted for suspected head injuries.</p> <p>The facility manager is aware of statutory responsibilities in regard to essential notification with examples provided (eg, reporting grade three or higher, pressure injuries).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>FA</p>	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (two healthcare assistants, two RNs, one chef) included evidence of the recruitment process, including reference checking, signed employment contracts and job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice that is specific to the job role. Staff interviewed</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>stated that new staff were adequately orientated to the service.</p> <p>An education and training programme is provided for staff that meets contractual obligations. In-service training is offered to staff every month and is linked to staff meetings. Competencies are completed specific to worker type and include health and safety, medication/insulin, infection control, hoist training, food handling, restraint minimisation, and fire evacuation. A register of current practising certificates for health professionals is maintained. Three RNs, including the facility manager, have completed their interRAI training. Two RNs have recently completed syringe driver training. Registered nurses and caregivers have received ongoing training that relates to the provision of hospital (medical) level of care including palliative care, supporting younger residents and manual handling techniques. Training records demonstrated that when a resident is admitted with a care need that is not familiar to staff, immediate training is given in brief form, prior to or at the time of admission and a more comprehensive training when this can be arranged.</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 staffing policy aligns with contractual requirements. The facility manager/RN is on-site five days a week and is on-call when not available on-site 24/7.</p> <p>There are two clinical leaders/RNs appointed who hold additional RN responsibilities. One clinical leader is on-site Monday – Friday and the second clinical leader covers night shifts and weekends. There is a minimum of one RN available 24/7. Two RNs are rostered during the am shift on Wednesdays to cover GP rounds and interRAI assessments. Staffing is flexible to meet the acuity and needs of the residents.</p> <p>There are adequate numbers of healthcare assistants available with staff extending their hours where needed. A pool of three casual staff are available. No agency staff is being used. Three healthcare assistants are rostered on the am shift, seven days a week (two long shifts and one short shift) and three healthcare assistants are rostered during the pm shift (one long shift and two short shifts). Healthcare assistant staffing is increased on Sundays to warm and serve the Sunday meals. The clinical leader interviewed stated that additional healthcare assistant responsibilities with meals on Sundays have not impacted staffing levels because residents are often away from the facility on Sundays with family. One RN and one healthcare assistant cover the night shift.</p> <p>A recreational officer is rostered four days a week (Monday – Thursday) from 9.00am to 2:30pm. The maintenance staff is also responsible for cleaning the facility. Healthcare assistants are responsible for laundry duties. A separate cleaner is employed four days a week.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory.</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 residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant healthcare assistant or RN, 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 been identified.</p>	<p>FA</p>	<p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager screens all potential residents prior to entry and records all admission enquires. Residents interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement form in use aligns with the requirements of the Aged Residential Care (ARC) contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require admission to hospital are managed appropriately and relevant information is communicated to the DHB. The facility uses the transfer (yellow) aged care envelope. Relatives are notified if transfers occur.</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>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. The medications are located in the nurses' station and all medicines are stored securely. Medication administration practice complied with the medication management policy, for the lunchtime medication round sighted. There were no residents self-medicating in the facility, but one resident takes a blister pack home when on leave. The resident has been assessed as competent to do this by the GP. Younger residents are supported to self-medicate if appropriate. There are no standing orders.</p> <p>The facility uses a blister pack system. Medications are checked on arrival and any errors recorded and fed back to the supplying pharmacy. RNs give medications to hospital residents. Healthcare assistants are permitted to give medications to rest home residents. Registered nurses and healthcare assistants are medication competent. There is annual education provided. The medication fridge is checked weekly. Eye drops are dated when opened.</p>

		<p>Staff sign for the administration of medications on medication sheets held with the medication charts. Medication administration signing sheets sampled corresponded with prescribed medications. Controlled drugs are checked by two people and the register is checked weekly.</p> <p>Twelve (six rest home and six hospital) medication charts were reviewed. All charts were legible, up-to-date and reviewed at least three monthly by the GP. There was photo ID on each medication chart and allergy status was recorded. 'As required' medications had prescribed indications for use recorded.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a well-equipped kitchen and all food is cooked on-site. There is one head chef who works Monday to Saturday 0800 – 1430. Healthcare assistants cover lunch, dinner and Sundays. The evening meal is prepared by the chef and the healthcare assistants heat and serve it. There is a food service manual in place to guide staff. There is a four-weekly seasonal menu (last reviewed by a dietitian 22 May 2017). A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. The facility has two options for residents to choose from at lunchtime. Special diets are catered for, along with those of different cultures. Residents interviewed were happy with the quality and variety of food.</p> <p>The service identified negative feedback and a number of complaints around meal services. In response to this, the service reviewed meals, the kitchen and meal services. A plan was put in place to improve services. This plan continues.</p> <p>The plan included training for staff, purchase of a bain marie, and a change to meal services. The service continues to offer two choices of main meal and dessert for the main meal at lunchtime. The cook serves the meal directly to residents from the bain marie. The chef interviewed stated they continue to review resident feedback weekly and alternatives are offered. There are more Chinese options (fried rice dish is cooked daily) offered for those Chinese residents. The weekly menu has enticing names for the meals to encourage resident appetite. The puree meals are presented attractively. Two to three different coloured vegetable options are offered. This accompanied with additional initiatives such as high teas, toasted sandwiches, and adapting supper to the resident's preference has resulted in increased resident satisfaction.</p> <p>To effectively evaluate progress, the service separated meal complaints from other complaints. There has been a marked reduction in complaints regarding meals. Monthly meal surveys have been positive; and the satisfaction rate has improved from of 68.4% in August 2016 to 86.4 % in September 2017.</p>

<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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 service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Six files sampled indicated that all appropriate personal needs information was gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and reviewed when there was a change to a resident's health condition. Care plans sampled were developed based on these assessments. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. InterRAI assessments had been reviewed six monthly.
<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The long-term care plans reviewed clearly described the support required to meet the resident's goals and needs and identified allied health involvement when required. The respite resident had a documented plan to guide staff around ensuring all needs are met. The interRAI assessment process informs the development of the resident's care plan. Residents interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Registered nurses and healthcare assistants follow the care plans and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or the mental health nurses). If external medical advice is required, this will be actioned by the GP. Staff interviewed confirmed they have access to sufficient wound supplies and continence products.</p> <p>Wound assessment and wound management plans were in place for seven residents with wounds. Two residents have pressure areas. All wounds have been assessed, reviewed and managed within the stated timeframes. On interview, the two RNs and the clinical leader stated that they could access the DHB wound or continence specialist nurse if they assessed that this was required. There was evidence in files of the wound specialist referrals.</p>

		Monitoring forms are in use as applicable, such as weight, observations, wounds and behaviour.
<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	<p>A recreational officer works 20-25 hours a week Monday to Friday. Healthcare assistants assist with activities on the weekends. Each resident has an individual activities assessment completed on admission. Care plans are developed from information gathered in assessment. In all files reviewed, interventions for activities were detailed for the specific resident and were age appropriate. The care plans reviewed had been evaluated six monthly at the same time as the long-term care plan.</p> <p>There are a wide variety of activities offered. The activities timetable is displayed in large print on the residents' noticeboard. There is a van outing with weekly trips to places of interest (visit to a local farm; walk in the winter garden of the museum; visit to the star dome). Special events like birthdays, Father's Day and spring are celebrated. Kindergarten children visit and provide story telling. Some residents attend activities of their own interest in the community. Church services are provided.</p> <p>Residents who prefer to stay in their room have one-on-one visits for discussion about topics of interest, hand massage and music. One resident enjoys swapping movies to watch. Each resident is free to choose whether they wish to participate in the group activities. Participation is monitored.</p> <p>The needs of younger residents are met by the staff completing a detailed assessment including the residents' interests, dreams, personality type (likes to be out in public/shy/outgoing etc.). Activities that already occur that may be of interest to the resident are discussed with the resident. Younger residents have a lounge space where they congregate. Community links are established with local community groups. For example, weekly Communicare groups, church services, and residents attend the local pool. Some younger residents assist staff with various activities and one resident takes music lessons for a student. Residents are able to come and go from the facility as they please. Residents who are able, regularly visit the local cafes and shops.</p> <p>Care staff reported they are aware of the resident's needs and interests including those related to the younger age of the resident. The registered nurse was aware of appropriate external resources to support the resident.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In files sampled, the registered nurses had evaluated the long-term care plans at least six monthly or earlier if there is a change in health status. The recreational officer evaluates the activities plan at the same time. There were at least three-monthly reviews by the GP. All changes in health status were documented and followed up. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the</p>

		care plan.
<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>The service facilitates access with other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. The sluice room is of an adequate standard. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.</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>	PA Low	<p>The building has a current building warrant of fitness (expires 25 June 2018). There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored, however, there is evidence of temperatures recorded above 45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have adequate internal spaces to meet their needs. External areas are accessible, and shade is available. The designated smoking area is not always adhered to by residents.</p> <p>The facility, including the layout, size of rooms and the number of lounge spaces are suitable for providing hospital (medical) level of care.</p> <p>Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Equipment such as oxygen, catheterisation sets, syringes and syringe drivers and pressure relieving devices are on site to meet the needs of hospital (medical) level residents.</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 requirements.</p>	FA	<p>In the rest home there are four rooms that share ensuites, ten that have a toilet and hand basin and one with a hand basin only. In the hospital (swing beds) there are two rooms which share a toilet and hand basin and sixteen which have a hand basin only. There are adequate communal showers and toilets. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas include one large lounge and dining area and a smaller lounge area that young persons can enjoy. These are large enough to cater for activities and these were observed taking 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>Healthcare assistants undertake cleaning and laundry tasks and once a week a contracted cleaner assists. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of the laundry and cleaning is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of the laundry and cleaning in the facility. Cleaning trolleys and chemicals are stored safely and securely. Safety datasheets are available. Laundry is completed off-site with only some personal laundry being done on-site. The laundry is small but adequate and is divided into a 'dirty' and 'clean' area. There is a cleaning and laundry manual.</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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum) with the last fire drill taking place on 19 May 2017. There is a New Zealand Fire Service approved evacuation scheme. The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas cooker is available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked monthly by maintenance.</p> <p>There is always at least one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. All staff are required to complete their first aid training.</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>There are electric panel heaters in resident rooms, communal areas and hallways. All rooms have external windows that open allowing plenty of natural sunlight and ventilation (link 1.4.2.6).</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>Remuera Rest Home has an established infection control programme. The infection control programme has been reviewed annually. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A clinical leader is the infection control coordinator. The infection control coordinator has support from all staff including the GP. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the GP and IC team at the DHB. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and hand sanitiser is freely</p>

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		available.
<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>	FA	Remuera Rest Home has infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff and has completed a Career Force infection control course. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required.</p> <p>Information is provided to residents and visitors that is appropriate to their needs. Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at monthly meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. Overall infection rates are low and there has been no outbreak since previous audit.

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraint minimisation. One resident was using a restraint and no enablers were in use. The facility has environmental restraint in place, which affects 18 residents. The entrance door is kept locked with the code to exit placed in a visible location. Written consent has been obtained for those (18) residents who are unable to freely exit the facility.</p> <p>Staff receive training on restraint minimisation. The healthcare assistants interviewed were able to describe the difference between an enabler and a restraint.</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 known to service providers and others.</p>	<p>FA</p>	<p>A restraint approval process is in place. Restraint minimisation policies and procedures describe approved restraints including environmental restraint. A clinical leader/RN is the designated restraint coordinator. He is knowledgeable regarding this role.</p>
<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>	<p>FA</p>	<p>The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is being implemented.</p> <p>The (rest home level) resident's file where restraint was being used was reviewed (note: this resident is currently being assessed for hospital level of care). The file included a restraint assessment, which included the identification of any risks associated with the use of a lap belt as a restraint. Restraint use was linked to the resident's care plan.</p> <p>Files sighted for residents that are environmentally restrained included identification of the risks of the environmental restraint within the assessment.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A restraint register is in place. The register identifies any residents using a restraint (or enabler), and the type of restraint used (including environmental restraint). The restraint assessment reviewed identified that restraint is being used only as a last resort.</p>

		The frequency of monitoring residents while on restraint (other than environmental restraint where this is not indicated), is documented. The resident using the restraint (lap belt) is being monitored every two hours while up in a chair. Note: the patient was last in a chair on 6 September 2017. Monitoring forms are completed when the restraint is put on and when it is taken off.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed three-monthly by the restraint coordinator, meeting requirements of the standard. Restraint use is discussed in the relevant staff meetings.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated as evidenced in the document control for restraint policies and procedures, in the meeting minutes and in discussions with the unit manager and restraint coordinator.

## 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 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	The service monitors hot water temperatures, however, hot water temperatures recorded for resident rooms were documented above 45 degrees Celsius.	Hot water temperature records reviewed (of random resident room temperatures taken) evidenced two to three per month were recorded above 45 degrees Celsius. There were no corrective action plans in place.	<p>Ensure hot water temperatures are managed within 40-45 degrees Celsius in all resident rooms and that there are corrective action plans in place where temperatures are outside the accepted range.</p> <p>90 days</p>
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	PA Low	The facility provides accessible outdoor areas and a designated smoking area for residents. However, the designated smoking area is not adhered to.	On the day of audit, a resident was observed to be smoking under the open window of the main lounge area.	<p>Ensure a designated smoking area is adhered to for comfort of all residents.</p> <p>90 days</p>

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

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

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

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

No data to display
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End of the report.