

Glenhays Limited - Southanjer

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: Glenhays Limited

Premises audited: Southanjer

Services audited: Dementia care

Dates of audit: Start date: 9 November 2017 End date: 9 November 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: 23

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 |
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|  | 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 |
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| 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

Southanjer is a stand-alone 24 bed dementia care rest home on the outskirts of Oamaru, the largest town in North Otago in the South Island. A 'sister' facility called Northanjer is a rest home on the main highway in the township of Oamaru. Both facilities are owned by a company called Glenhays Ltd., which purchased them in May 2017. A couple who are the majority shareholders manage these facilities.

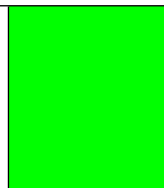
This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

Evidence obtained throughout the audit confirmed that the service has continued to function at a high level and that residents and family members remain satisfied with the services provided.

There were no areas identified as requiring improvement at the previous audit; therefore, only criteria required for a routine surveillance were audited. No corrective actions were identified during this audit event.

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.



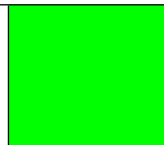
Standards applicable to this service fully attained.

Family members confirmed during interview that the manager and staff communicate with them in an open manner and keep them updated about their relative. Regardless of their level of comprehension, staff were observed to maintain open communication with the residents. The service provider has contact details for interpreter services should they be required.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

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.

The operations manager/manager and the business manager live on site, although the latter is out of town three days a week. With a registered nurse alongside her, the operations manager is responsible for the services provided at this facility. A documented business plan and a quality and risk management plan include the scope, goals, and mission statement of the organisation. Systems are in place for monitoring the services provided.

The manager is a registered physiotherapist who is quickly gaining experience in the management of this facility and developing suitable skills and knowledge. Quality and risk is being managed via an annual calendar of internal audits, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and family satisfaction. Collection, collation and analysis of

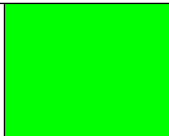
quality improvement data is occurring and is reported to the quality and staff meetings. Adverse events are documented and followed up as opportunities for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from families is used to improve services. Residents are consulted, but non-verbal cues, rather than conversation, are indicators of their level of satisfaction. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, were current and reviewed regularly.

Human resources policies and procedures are based on current good practice and guide the systems for recruitment, appointment and management of staff. A comprehensive orientation and staff training programme ensures staff maintain the required competencies for their role. Systems are in place to provide ongoing staff education and record achievements. Staff have access to external training opportunities.

Staffing levels and skill mix meet contractual requirements; reflect the type of service provided and the changing needs of residents. An on-call system ensures the manager is readily available and staff always has access to registered nurse advice and support.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |
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The manager lives on site and is able to contact the registered nurse from this facility during her rostered on-call times, or otherwise, contact the registered nurse living on site at their other facility down the road. Shift handovers guide continuity of care.

Care plans are individualised and based on a comprehensive range of clinical information. Short term care plans are developed to manage specific or new problems that might arise. All residents' files that were reviewed demonstrated that needs, goals and

outcomes are identified and reviewed on a regular basis. Family members reported during interviews that they are well informed; involved in decision-making and that the care provided is of a high standard.

A planned activity programme is coordinated by an activity coordinator who is supervised by a qualified diversional therapist. There is a second activities person and the manager encourages caregivers to assist residents with activities at every opportunity. The programme provides residents with a variety of individual and group activities and enables them to maintain links with the local community.

Policies and procedures on medicine management based on current good practice are available. Medicines are stored safely, administration records are accurate, and reconciliation processes meet requirements. The manager and registered nurse undertook a recent review of medicine management. Medications are administered by caregivers who are considered able to take on the associated responsibilities and have completed a medicine administration competency.

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. Residents who require assistance with their meals receive this. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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The building has a current building warrant of fitness. There have no modifications to the building since the last audit.

Restraint minimisation and safe practice

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| 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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Policies and procedures on restraint minimisation and safe practice were in place. The manager reported that there are no enablers or restraints being used and that staff education on restraint focuses on early intervention and de-escalation techniques. Staff confirmed that there are no restraints in use at Southanjer and that they received restraint training at orientation with follow-ups approximately every two years. They demonstrated an awareness of different types of restraint and were aware of the specific documentation required when they are used.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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All infections are recorded on a reporting form. Aged care specific infection surveillance is undertaken, with the graphing and analysis of infection data being completed monthly. The registered nurse/infection control coordinator subsequently provides reports that are presented to staff and quality meetings. Resulting follow-up actions are recommended and relevant education is provided when indicated.

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> | FA | <p>A complaints policy, procedure and associated forms meet the requirements of Right 10 of the Code. The information is passed on to family members by the registered nurse or manager when a new resident is admitted. Information about making a complaint, brochures on accessing the advocacy service plus copies of complaints forms are in the lobby at the entrance to the facility.</p> <p>The complaints register was reviewed. This showed that six complaints, some of which had been verbally expressed dissatisfactions, have been investigated since the facility manager took over in May 2017. The facility manager is responsible for complaints management and follow up. Notes, records of the actions taken and copies of the related correspondence were on file and demonstrated required timeframes had been met and all had been resolved. Action plans reviewed show improvements have been made where possible. Staff confirmed during interview that they fully understand the complaint process and know what the advocacy service is.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p> | FA | <p>Staff who were interviewed understood the principles of open disclosure. An open disclosure policy document meets the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Family communication recording</p> |

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| <p>effective communication.</p> | | <p>forms are being completed and copies were sighted in residents' files. Residents were not able to specifically comment on the level of communication staff have with them; however, observations throughout the day confirmed staff maintain communication regardless of the residents' level of understanding. During interviews with family members, it was noted that staff keep them updated. A review of adverse event forms verified that family members are advised following their family member experiencing an incident/accident.</p> <p>An interpreter policy is in the policy manual. Interpreter services are able to be accessed via the local hospital and wider District Health Board should they be required.</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>Southanjer and its sister rest home Northanjer on the main highway through the township of Oamaru are managed by an operations manager and her partner who is the business manager. They are the majority shareholders in a company called Glenhays Ltd. The company purchased the facilities in May 2017 and although the manager's partner lives in another town for some of the week, he commutes to assist with maintenance and provides advice and support as appropriate. There is a team of business advisers and accountants supporting the managers. A business plan developed in April 2017 sits alongside a quality and risk plan in outlining the purpose, values, scope, direction and goals of the service. The documents describe annual and longer term objectives and the associated operational plans. These focus on qualities such as dignity, respect, friendliness, treating people as individuals and providing a homelike environment.</p> <p>The manager is a qualified physiotherapist who has a current practising certificate, specialist knowledge in neurological rehabilitation and extensive experience in rehabilitation of the older adult. She has been in the role since 22 May 2017. The previous manager assisted her with a planned orientation over a three month period and continues to be available to answer questions. Since commencing her role at Southanjer, the manager has completed interRAI training for managers, has attended the Aged Care Association Conference, completed assessor training through a training facility and has enrolled in an auditing in healthcare training course.</p> <p>During interview the manager confirmed she has developed some strong networks, continues to be committed to the task she and her partner have taken on and is fully aware of her limitations. The manager was able to describe regulatory and reporting requirements. She is assisted by a registered nurse and it was observed how well they work as a team to manage this facility. They also work alongside the registered</p> |

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| | | <p>nurse from Northanjer.</p> <p>The service holds a contract with the local District Health Board to provide rest home dementia care services. Respite care may be provided when beds are not occupied by a person receiving long term care.</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>Southanjer's manager has access to the quality consultant who was used by the previous manager. The quality consultant has provided a quality and risk plan, which has proven suitable for small aged care facilities, including the Southanjer and Northanjer homes. The plan is based on a 'Strengths, Weaknesses, Opportunities and Threats' (SWOT) analysis of various operational aspects of the service. Staff were familiar with the system and spoke of aspects of it, such as incident reporting, complaints and internal audits during interviews. Systems implemented for managing quality and risk are identical at both Northanjer and Southanjer homes. The quality committee meetings are combined; however, the data is kept separate. Information is shared with the manager and the registered nurse and representative caregivers from both homes, in order to enhance the learnings.</p> <p>Policy and procedure documents, including one on document control, were current with the last review being October 2017. These have been supplied by, and are being maintained by, the quality consultant. There was no evidence of obsolete documents and all were in the required format.</p> <p>Implementation of the quality and risk management plan was evident in the monthly staff meeting minutes, the three monthly residents' meeting minutes and the minutes of a general committee meeting. All meeting minutes demonstrated staff involvement and included details on internal audits, complaints, hazards, risks, infections and a range of reports on health and safety and resident related care issues. Reports include analyses of quality related data and internal audit and survey results. Corrective actions have been identified and are followed through to improvements.</p> <p>The risk management plan has clearly identified risks. Each identified risk has a list of monitoring processes against them that are a component of one part or another of the quality and risk management system. A person(s) responsible for the ongoing monitoring is identified. The manager and staff were positive about the systems in place and reference to their effectiveness was in a recently published newsletter for Southanjer.</p> |

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| <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>During interview, the manager was able to quote a range of circumstances that would require reporting to a higher authority. Examples included reporting pressure injuries, death of a resident, significant injuries, and the routine quarterly contract reports, for example. A copy of a document on essential notification reporting requirements has been strategically positioned in the manager's office/nurses' station to facilitate ease of reporting such events. A norovirus outbreak was reported as required shortly after the manager took over the facility in May 2017.</p> <p>Policy and procedures on the management of incidents/accidents and adverse events were sighted. Incident forms are completed by the staff involved in the adverse event. Staff confirmed that completing these is automatic for them when things go wrong. All of the incident forms that were reviewed during the audit had been followed up by the registered nurse and/or the manager. The section on open disclosure demonstrated who had been contacted and when. Each incident was individually followed up and a summary feedback report developed. Monthly incident/accident forms have been completed and graphs developed. Incidents had been collectively analysed over time and is enabling identification of 'frequent fallers' or staff more likely to make a medication error.</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>A suite of human resources related policies, procedures and forms that cover recruitment, employment and training of staff were reviewed. Annual practising certificates for health professionals who provide services to the residents (eg, as a GP, nurse, pharmacist, physiotherapist and podiatrist), have been verified and reviewed for currency.</p> <p>Staff files were reviewed and demonstrated the policies and procedures are being implemented with evidence of formal applications being made, police and referee checks, staff interviews and an induction process. Southanjer has some long standing staff members and the entry records were not necessarily complete in their files. All had a current and renewed employment contract and signed position description.</p> <p>The orientation programme is comprehensive and where records were available, they demonstrated the topics had been checked off and signed. Staff performance appraisals were mostly due in August and September 2017. Although a three monthly review had been undertaken with new staff, the manager informed she had purposely not undertaken performance appraisals as she wanted to settle into the role and enable staff to get to know her, and vice versa, prior to proceeding with them.</p> |

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| | | <p>Relevant competencies, including medication, first aid and emergency management, were up to date for all staff. A 2017 and a 2018 calendar for staff in-service training is in place and includes a variety of on-line and formal presentations from both internal and external people. The topics were consistent with contractual requirements, including the need for all staff to have completed or be undertaking education about dementia care. Records of staff training are being maintained in staff files and in an education folder in which overviews and attendance records for in-service sessions are filed. Caregivers confirmed they have ample training opportunities and confirmed they are being encouraged and assisted to undertake externally facilitated certificate courses to upskill and broaden their knowledge.</p> |
| <p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>A policy and procedure on staffing and the principles behind the rostering of staff was reviewed. Since coming into the service in May, the manager had reviewed the task list for each shift and subsequently made some small changes, such as re-delegation of duties and changes of timeframes of when certain duties, such as heavy kitchen cleaning, were completed. The manager informed that most decisions related to safety, efficiency and increasing residents' activity time.</p> <p>The manager is on call Monday to Thursday and the registered nurse is on call for the balance of the time, although is also available by phone when the manager is on call. Both the manager and registered nurse also have access to the registered nurse from Northanjer who lives on site there. There is also an on-call system for accessing a GP at all times.</p> <p>Three caregivers work morning shift and the cook assists when relevant. An activities person works 9m to 3pm. Three caregivers with varying hours also do afternoon shifts. One person works night shift, although has access to the on-site manager when necessary. A second person works nightshift Friday to Sunday inclusive.</p> <p>Monday to Friday, the manager works throughout the day and the registered nurse works some mornings and some afternoons. Otherwise the roster notes who the most senior person on duty is. When not obvious, the medicine administrator is also identifiable. All staff including the two activities coordinators have first aid certificates and the currency of these is monitored.</p> |
| <p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative</p> | FA | <p>The medication management policy is current and identifies all aspects of medicine management in line with legislation and the Medicines Care Guide for Residential Aged Care.</p> |

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| <p>requirements and safe practice guidelines.</p> | | <p>Safe systems for medicine management were observed on the day of audit. The staff person observed prior to and during the lunchtime medicine round demonstrated good knowledge and had a clear understanding of her role and responsibilities. All staff who administer medicines have a current medicine administration competency.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the registered nurse against the prescription. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and the registered nurse noted they are seldom used. There were no controlled drugs in use on the day of audit, however the controlled drug register was still checked and demonstrated weekly checks are made.</p> <p>The medicine records of eight residents were reviewed. Good overall prescribing and administration recording practices were noted and included that the prescriber's signature and date is recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. The required three monthly GP review was consistently recorded on the medicine chart.</p> <p>There were no residents in this dementia service who were self-administering any of their medicines.</p> <p>Medication errors are reported to the manager and to the registered nurse and are recorded on an accident/incident form. The usual adverse event process is followed through with an analysis of medication errors completed within the quality management system. Compliance with this process was verified.</p> <p>Neither standing orders nor verbal orders are used at Southanjer.</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>Food is cooked on the premises by two cooks. One was interviewed during the audit and demonstrated a good understanding of the residents' nutritional needs. The menu, which was reviewed by a dietitian in February 2017, rotates every five weeks. This was still in the winter option cycle on the day of audit with the change to summer options planned on the meat order day of the following week.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The registered nurse provided examples of speech language therapy involvement. Personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. One of the cooks has developed an individual name tag</p> |

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| | | <p>system, which is ensuring residents receive the correct meal as each tag includes the person's needs and preferences. Residents have access to food and fluids at all times and staff provided examples of heating food and providing supplements when some residents choose to eat, rather than relying on meal times. Staff were observed to take time to feed residents and consider their individual needs. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored daily, as are fridge and freezer temperatures. The cooks and caregivers involved in the kitchen have completed relevant food safety training. A cleaning schedule is signed off daily and the heavy cleaning is now completed by night staff.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>The provision of care provided to individual residents was consistent with their identified needs, goals and intervention in their service delivery plans. Documentation, observations and interviews verified that the care and support is individualised. Caregivers, the registered nurse and the manager were opportunistic when managing the residents, especially those who were more challenging.</p> <p>The GP expressed satisfaction with the timeframes he is contacted in, is satisfied that his recommended treatments are followed through and that the clinical judgements of the registered nurse are relevant for the dementia service. He noted that staff do not take risks beyond their level of expertise.</p> <p>Caregivers confirmed that they receive handovers before each shift, which are especially valuable if they have been away, or someone's condition has changed. They stated that they read and contribute to the residents' care plans. Relatives confirmed during interview that the level of care provided at Southanjer is excellent and its good reputation is being maintained. Some residents said the staff were good and others said they would rather be at home. None said they were unhappy.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>A personal profile record that includes a social history is completed with family members as far as possible at the time of each resident's admission. One person had a written profile of his life that he had completed in earlier years, on file. Information is extracted from the profile and used to assist in the development of a personal activity plan. Personal activity plans include an hour by hour overview of ideas to motivate the resident over a 24 hour period, seven days a week.</p> |

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| | | <p>The activities coordinator is part way through her diversional therapy training and is meantime supervised by a qualified diversional therapist. She is completing all planning, attendance, review and evaluation records within appropriate timeframes whilst also implementing a planned programme. The programme is diverse and covers a range of individual and group activities that are consistent with the residents' profiles and personal interests. A second activities person assists with implementation of the programme. Observations of the activities in progress throughout the day demonstrated the wider staff involvement, which the manager encourages. Some residents talked about some of the things they like doing best and relatives interviewed noted how a lot of the residents get involved in the activities on offer, or potter around outside in the garden.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Caregivers are responsible for reporting any change in a resident's condition to the registered nurse or the manager at the time they notice it. They complete their own progress notes. The registered nurse has her own progress notes where significant changes are recorded and updated. These are used for consideration of the possibility that a short term care plan may be needed and for a quick reference to see if an acute event or an observed change in behaviour or functioning had been noted at an earlier time.</p> <p>Formal evaluations of service delivery plans are completed every six months. These follow the six monthly interRAI reassessment. Evaluations and reviews are also completed when a person's condition changes with an example being for a person who had become increasingly sleepy of late. The registered nurse was also reviewing the functioning of a person who has displayed inexplicable behaviour changes. Medical reviews are consistently occurring three monthly for most residents, or at the frequency determined by the GP. Service delivery plans are updated and signed by the registered nurse whenever a resident's condition changes. Many examples of these were evident.</p> <p>Short term care plans that are in place for short term problems, such as skin tears, bruising post a fall, or a urinary tract infection, are reviewed most days or according to its associated treatment. Families/whānau interviewed provided examples of their involvement in evaluation of progress and are comfortable with the level of involvement they have.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p> | FA | <p>A current building warrant of fitness, which expires 9 April 2018, is publicly displayed in the lobby at the entrance to the facility. There have been no modifications to the building since the last audit; therefore there has been no</p> |

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| fit for their purpose. | | change to compliance requirements such as approval of the fire evacuation plan. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The infection prevention and control policies and procedures describe the process for the surveillance of infections. Surveillance of infections is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. One of the roles of the registered nurse is to take on the responsibilities of infection control coordinator, including infection surveillance.</p> <p>Any identified infections are recorded on an infection record form and the information transferred onto a monthly infection record form. The information is graphed and a summary of analysis of the data for that month is included on the form. Comparisons with data from previous months are made and any trends identified. Although the services at the sister facility (Northanjer rest home) are slightly different, the data from there is discussed and compared at the same meeting and messages are shared. Records sighted included suggestions for the prevention of recurrence of the identified infections.</p> <p>The infection control coordinator noted that a spike in infections in October 2017 related to the common cold that had spread among residents and staff. There was evidence of recommendations provided to staff. Staff interviewed informed they are required to read the policy documents and are aware of the need to report infections and complete the record form as much as they can. They informed they receive feedback through handovers and meeting minutes and attend education sessions.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The manager is also identified as the restraint coordinator and during conversation demonstrated a sound understanding of the organisation's restraint policies and her responsibilities.</p> <p>At the time of audit, there were no residents at Southanjer who had been assessed as requiring any of the approved forms of restraint. There were also no enablers in use at Southanjer. Staff confirmed this to be the current situation at Southanjer and noted that no form of restraint has been used for years. Restraint use is an agenda item in quality meeting minutes and staff meeting minutes. Information about restraint/behaviour management training is commented on in the meeting minutes, as is a summary of instances when staff have had to use significant de-escalation techniques.</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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| No data to display |
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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.