Ranfurly Manor Limited - Nelson Residential Care Centre

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 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:	Ranfurly Manor Limited
Premises audited:	Nelson Residential Care Centre
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 December 2017 End date: 5 December 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: 22

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Nelson Residential Care Centre provides rest home care for up to 49 residents. The service is operated by Ranfurly Manor Ltd and managed by a facility manager, overseen by a general manager. Residents and families spoke positively about the care provided.

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

This audit has identified one area requiring improvement relating to medication management. This is the first certification audit at the facility since it opened in March 2017. The one area for improvement identified at the facility's partial provisional audit in February 2017, related to receiving a Certificate of Public Use prior to occupancy. This has been addressed. One area of strength was identified in relation to the planning and delivery of ongoing education.

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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Nelson Residential Care Centre. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints 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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in integrated electronic and hard copy files.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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.

Nelson Residential Care Centre is a restraint free environment. The organisation has implemented policies and procedures that support the minimisation of restraint. All staff have attended training on restraint minimisation and safe practice. There were no restraints in use.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed within the organisation's

clinical expertise and the infection control nurse at the Mid-Central District Health Board (MCDHB). The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	44	0	0	1	0	0
Criteria	1	91	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Nelson Residential Care Centre has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaint policy for the facility meets the requirements of Right 10 of the Code and these standards. This is given to all new residents and families on entry to the service, all new staff at orientation and at an annual manual training. (See also Standard 1.2.3) The complaint register is maintained by the facility manager and demonstrated that required timeframes have been met. The issues raised are being managed appropriately. The facility manager demonstrated a sound understanding of the Code and his responsibilities for complaint management. There have been two formal complaints lodged since the facility opened in March 2017. Staff members interviewed also demonstrated a clear understanding of their responsibilities, their role in reporting residents' concerns and complaints and directing complainants to the available complaint forms and the Health and Disability Commissioner's pamphlets, which were freely available within the facility. The October 2017 resident satisfaction survey, includes the question 'If I have concerns, I feel comfortable raising them, my concerns are responded to promptly.' 92% responded 'Always' to this question, with the remaining 8% (one person) responding 'Mostly'.
Standard 1.1.2: Consumer Rights	FA	Eight residents and one family member interviewed, report being made aware of the Code and the

During Service Delivery Consumers are informed of their rights.		Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and the one relative interviewed confirmed that they/their relative receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately and exchanging verbal information and discussion with families and the General Practitioner (GP). All residents have a private room. Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There are no residents in Nelson Residential Care Centre at the time of audit who identify as Māori, however interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. The organisation has recently commenced a review of their Māori health plan, following feedback from Māori residents and family/whānau at another one of the facilities owned by the organisation. The review has included the forming of a Māori caucus, that includes members of the local iwi, Māori staff, Māori chaplains, community and facility representatives. The caucus will review, advise and provide guidance on the implementation of processes that enable the organisation to diversify in meeting the cultural needs of its residents.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. Registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, services for older people, a psychogeriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive managements support for ongoing education to support contemporary good practice. Other examples of good practice observed during the audit included: an ongoing commitment to improving staff access to education; the implementation of processes allowing the facility to be more 'homely', for example, the change in breakfast routine to encompass a smorgasbord set up in the dining room, with residents serving themselves and choosing what they would like to eat each day; walking groups; and outings based on daily requests from residents.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and the family members interviewed stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed when required, with signs around the facility providing the phone numbers for interpreter services. Staff reported interpreter services were rarely required due to all present residents being able to speak English. One resident with English as a second language has 'cue' cards in her room for staff to use if communication is difficult.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Nelson Residential Care Centre (NRCC) is privately owned by a single owner. It is one of three facilities owned by the same person. The facility manager reports to the general manager who is responsible for the group of three facilities. There is a care manager and a clinical quality support registered nurse (RN), who, along with a general manager, are based at a second facility in Fielding. The care manager and clinical quality support RN are available to provide assistance to NRCC. The general manager was present, and interviewed, during this audit. The mission, vision and values of the organisation are documented in the business plan for the facility. This was developed shortly before opening in March 2017 and the facility manager reports against the objectives and targets in this plan through his monthly reports. Because the facility has only been open for nine months at the time of this audit, the plan is not yet due to be reviewed until March 2018. The general manager receives monthly reports from the facility manager, has frequent meetings and other contact with him. The facility manager is a registered nurse who maintains his practicing certificate. He was appointed to this position in January 2017. Prior to this he held a clinical management position with a facility management component for two and a half years. He has been a RN for eight years. Prior to this he worked for the Ministry of Justice. NRCC can accommodate up to 49 residents. On the day of the audit there were 22 residents. Nine residents had been assessed as requiring rest home level care and were paying privately, eleven residents are funded by the provider's contract with the local District Health Board (DHB) for aged related residential care, one resident was receiving respite care under the DHB contract, one resident was under 65 and funded by the Accident Compensation Corporation. The provider also has a contract with the Ministry of Health for the provision of services to people who are under 65 and require residential services, although there were no residents receiving services under this contract at the time

		of the audit.
Standard 1.2.2: Service Management 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.	FA	In a short term absence of the facility manager, the other RN will undertake the role of facility manager, with support from the facility on call and the senior staff at the other facility in Fielding. In a longer term absence, the facility manager from the other facility would cover the position with the general manager covering that person's role at the second facility. At interview with staff members they report that the facility manager is providing positive leadership at the facility and he is approachable both for staff and for residents and families.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of accidents and incidents, complaints, internal audit activities, resident meetings and an annual resident satisfaction survey, infection rates and the use of restraints and enablers. Due to the size of the facility the staff meeting is used to combine the meeting requirements of general facility issues, resident issues, quality and risk management, infection prevention and control and restraint minimisation and safe practice. Meeting minutes reviewed confirmed regular discussion and review of the quality indicators. These meetings include quality and risk management activities, internal audits and any relevant corrective actions. Resident and family satisfaction issues are also discussed, and at the end of October 2017, the resident satisfaction survey was completed. The most recent survey showed high satisfaction rates. Percentage ratings are included against appropriate standards throughout this report. Policies are developed for the three facilities in the group. Those reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The GM and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.

Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of accident/incident forms reviewed showed these were fully completed, events were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported by the facility manager. Staff confirmed that they receive summarised information at staff meetings and discuss responses to individual adverse events and any trends which emerge. The GM and facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events made to the Ministry of Health since the facility opened in March 2017. These involved two separate occasions of residents unable to find their way back from a walk. Appropriate individual and systemic corrective actions were implemented in response to these events.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three-months in the role and then annually. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of three monthly performance appraisals. Annual performance appraisals are not yet due. An area of continuous improvement is identified in relation to the planning and delivery of ongoing education. Staff members interviewed reported that they have received appropriate education to support them in their roles. In the October 2017 resident satisfaction survey 77% of respondents indicated that they 'Always' thought the nursing staff were professional and supportive, with the remaining 23% (3 respondents) indicating 'Mostly'.
Standard 1.2.8: Service Provider	FA	There is a staffing policy which describes how the roster will be developed to meet the needs of residents in the facility at any point in time. Rosters are compiled by the facility manager using an

Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		electronic rostering tool. The interRAI data and other resident acuity information is used to inform staffing levels. Rosters for the fortnight prior to and including the week of the audit were reviewed. These demonstrated levels of staff consistent with the organisation's staffing policy and as required by their contracts. The roster currently provides for one RN on the morning shift and an enrolled nurse on the afternoon shift Monday to Sunday. During week days this is in addition to the facility manager. The facility manager and RN share on-call duties from 5.30pm – 7am during the week and over weekends. There are a varying number of healthcare assistants throughout the facility, and across the three shifts every day. When occupancy numbers have been higher these numbers have increased. There is a cook and trained kitchen staff from 7am daily, seven days a week. There is a laundry and a cleaning staff daily from 9am – 1pm, seven days a week. There is a diversional therapist who works Monday – Friday 9am – 3pm. The current staffing levels meet the requirements of residents. Staff members interviewed reported that there are sufficient numbers of staff rostered on each shift for them to be able to do their job safely and well. When numbers of residents have increased, staffing numbers have increased to meet needs. Residents and the family members interviewed also confirmed that there are adequate numbers of staff.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. The facility has only been open a year and there were very few archived records, however these are held securely on site and are readily retrievable using an electronic cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the RN. They are also provided with written information about the service and the admission process. Family and the resident interviewed stated they were satisfied with the admission process and the

services has been identified.		information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes. This was evidenced in the recent transfer of a resident to MCDHB.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed on a medication round demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the RN or FM against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. The records of temperatures for the medicine fridge were within the recommended range. A review of electronic medication records verified good prescribing practices, including the prescriber's electronic signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart. There was however an inconsistency between the electronic prescription and the paperwork documenting the required dose of warfarin. This is an area requiring corrective action. There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and FM and recorded on an accident/incident form. The

		resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. Standing orders are not used.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in September 2017 All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The food service has a food control plan in place and this has been verified by the Manawatu District Council (15 May 2017). Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The qualified chef has undertaken a safe food handling qualification and a diploma in nutrition, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. An initiative to offer a more smorgasbord type approach at breakfast, has been implemented. Breakfast is available between 7.30 am and 9 am in the dining room. Residents have a range of choices available to them, and they help themselves. Interviews evidenced satisfaction and improved independence with this change.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the RN. There is a clause in the access agreement related to when a resident's placement can be terminated.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as, pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the two trained interRAI assessors on site.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and the one family member reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by a trained diversional therapist. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan review. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include a number of outings and involvement in community activities. Individual, group activities and regular events are offered. Examples included sit and be fit, three walking groups (membership of each group

		based on walking speed), visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Newspaper articles capture the events the residents of Nelson Residential Care Centre have undertaken since its opening. Photographs in an album document outings, to enable families to be familiar with what is going on. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. A younger resident's differing needs and individualised activities programme is well documented in the care plan. The programme has enabled an improvement in the resident's mobility and the resident is now participating in the daily walking groups and there is increased socialisation with the resident now choosing to participate in outings and activities of interest on a daily basis. Interview with the resident verified satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and the family member interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste, infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this. At interview with staff members, they reported that they have sufficient supplies of personal protective equipment to undertake their roles safely. They can access assistance from the contracted company should this be required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The facility has been open for less than a year after being completely reconfigured and refurbished. There is a current Code Compliance Certificate issued on 28 February 2017. This is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The majority of equipment was purchased new for the facility prior to opening. The testing and tagging of the small amount of electrical equipment which is not new and required an annual check has been done. There is a register for this that includes the calibration of bio-medical equipment for when this is due. The environment is hazard free, residents are safe and independence is promoted, as was observed during the audit. Residents were moving around the facility, either independently or using mobility equipment. External areas are safely maintained and are appropriate to the resident groups and setting. Internal and external areas promote independence with ramps (when needed,) flat walkways which are in good condition outside, handrails inside, and low rolling resistance or non-slip flooring.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a mix of bedrooms with shared full ensuite bathrooms (6 bedrooms), bedrooms with shared ensuite toilets (ten) and shared bathrooms (five) and toilets (seven) throughout the facility. Appropriately secured and approved handrails are provided in the toilets and showers. Other equipment and accessories are available to promote residents' independence. Four of the rooms with shared ensuites are used by couples and one is used by a permanent resident who shares with a respite resident who uses the facility occasionally. These latter two residents are happy to share with one another and the two couples choose to share also. There are additional toilets for visitors and staff members. Staff members reported that there are

		adequate showers and toilets for residents, visitors and staff members.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Where rooms are shared approval has been sought. This is the case for the couples who live at the facility. In each case they have chosen to use one room as a shared bedroom and the other as a living room. Rooms are personalised with furnishings, photos and other personal items displayed. There are areas to store mobility aids. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There is a dining room adjacent to the kitchen and two large lounge areas. These are all spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. The laundry staff member interviewed has completed the New Zealand Qualifications Authority Certificate in Cleaning and Caretaking (Level 2). There is a designated cleaning team who have received appropriate training. These staff are able to undertake the New Zealand Qualifications Authority Certificate in Cleaning and Caretaking (Level 2), and complete the training available in the facility. This was confirmed during interview with cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme. The internal audit demonstrated that cleaning and laundry is being completed as is required by the organisation's policies and procedures. The October 2017 residents' satisfaction survey included questions about laundry and cleaning

		services. 77% of respondents noted that the laundry 'Always' takes good care of their clothes and returns them (to the resident) promptly, while 23% think that this 'Mostly' happens. 77% of respondents also responded that they are 'Always' happy with the cleanliness of their rooms and 23 % were 'Mostly' happy. In relation to the facility, 69% of respondents are 'Always' happy with the cleanliness of the shared areas of the facility and 31 % were 'Mostly' happy.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 17 January 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 21 September 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and a gas BBQ are available at the facility and meet the requirements for the number of residents. Water is stored and located around the complex. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows with curtains which are in good condition and provide effective covering. Some rooms have doors which open onto an internal courtyard patio area. Heating is provided by gas fired central heating in residents' rooms and in the communal areas. Areas were well ventilated throughout the audit and residents and the family member interviewed confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control	FA	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme.

management 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.		Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the FM. The infection control programme and manual are reviewed annually. The FM, with input from the organisation's quality improvement and clinical support co-ordinator, is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the staff/quality meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's general manager is informed of any IPC concern. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICC has appropriate skills, knowledge and qualifications for the role, however is supported by the organisation's quality improvement and clinical support co-ordinator, and a RN with a post graduate certificate in IPC. Well-established local networks with the infection control team at the DHB are available if required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures 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	FA	The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.

appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids and ice blocks during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality/staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 facility manager is the restraint coordinator for Nelson Residential Care Centre. There is also a restraint coordinator based at the second facility in Fielding. She provides support to the facility manager at NRCC when needed. The facility does not use restraints and there are no residents who have requested enablers. Residents are supported to remain active and independent. The system for restraint and enabler management was evident in the facility should it be required, and

		staff members interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Documentation around the one resident on warfarin evidences an inconsistency with authorisation by the prescriber on the electronic prescription and the documented dose recommended on the paperwork from the laboratory. The electronic record requests different dosages on alternate days, however the laboratory documentation requests five days of one dose and on two specified days, a different dose. The inconsistency has not been detected prior to audit. During the audit the prescriber was contacted, to clarify the request, update the electronic record and ensure consistency between both processes that support the dosing of warfarin.	There are inconsistencies around the warfarin dose authorised by the prescriber on the electronic prescription and the documented dose required on the paperwork from the laboratory, which advises the prescriber of the required dose. The inconsistency was sighted during audit, however had not been identified during medication administration.	A review of the system is required to ensure consideration is given to acknowledging the laboratory result when administering warfarin and ensuring that the dose is correct. 30 days

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	Orientation was completed for staff employed prior to the facility opening. Ongoing training was scheduled and delivered as individual sessions in the first half of 2017. Attendance was low with mostly the same five staff members, the core group, attending each session. In June, the facility manager conducted a review of training attendance and changed the method of delivery from individual sessions run each month, to a day- long session combining all required topics. Staff members were rostered to attend a day of mandatory training. This commenced from August 2017 until all staff had attended. Staff meeting minutes document the process of problem identification, review and analysis, development of the new initiative and implementation. Evaluation of the results were presented as graphed data showing the significant change in staff attendance from the first half of 2017 to full staff attendance at training by October 2017. Positive feedback from staff about the change in delivery is also recorded in the minutes and this was confirmed at interview during the	The planning and implementation of required education has been reviewed and revised to ensure that there is full attendance by all staff of the facility. An analysis of attendance, delivery methods and session content occurred. A one-day programme with more interactive content has led to full attendance over a shorter time frame. Staff members competencies, as a consequence of attendance at training, are up to date.

		audit.	

End of the report.