

Y&P NZ Limited - Deverton House Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Y&P NZ Limited
Premises audited:	Deverton House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 March 2018 End date: 28 March 2018
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:	20

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Deverton House Rest Home is one of two facilities owned by Y&P NZ limited. Deverton House Rest Home provides rest home level care for up to 21 residents. There were 20 residents receiving care at the time of this audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, a review of residents' and staff files, observations, and interviews with residents, family members, the manager, staff, the owner/director and the general practitioner. Feedback from residents and family members was positive about the care and services provided. An independent Cantonese and Mandarin speaking interpreter was utilised for interviews where required.

The three areas requiring improvements from the previous audit related to training on restraint minimisation and use of enablers, ensuring the registered nurse had a current medicine competency, and reviewing the hazard register have been addressed by the service and are now fully attained. There are nine new areas identified for improvement from this audit related to the manager's role, managing hazards, completing annual staff performance appraisals and ensuring staff rostering is appropriate. In addition, improvements are required related to aspects of timeliness of care, documentation and communication, interventions, activities, ensuring changes are made to care plans or short-term care plans developed for changes in condition, and aspects of medication storage.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service demonstrates residents' rights to full and frank information and open disclosure principles are met. Independent interpreter services are accessible; however, family and staff who speak the residents' language normally are used wherever necessary to ensure good lines of communication are maintained with residents and family members.

Complaints management is well documented. All processes are undertaken to meet the standard's requirements. Complaints are uncommon. There are no open complaints at the time of audit.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation's philosophy, mission and vision statements are identified in the 2018 business plan. The facility manager, the owner/director and the registered nurse / clinical nurse manager work together to ensure the service planning covers business strategies and care provision.

The quality and risk system and processes support effective, timely service delivery. Policies and procedures are developed by an external consultant and updated to reflect Deverton House Rest Home service. The quality management systems includes an internal audit programme, compliments, complaints management, incident/accident reporting, benchmarking with other facilities, resident satisfaction surveys, and enabler and infection control data collection. Quality and risk management activities and results are shared with the owner/director, staff, residents and families, as appropriate. Corrective action planning is documented.

New staff have an orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and families confirmed during interview that all their needs and wants were met. The service has a documented rationale for staffing.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents` needs are assessed by the clinical nurse manager who works across two aged care facilities owned by the organisation. The clinical nurse manager oversees the care provided to the residents. Senior care staff are on duty 24 hours, seven days a week. The facility manager and the clinical nurse manager are supported by a designated general practitioner, podiatrist and care staff. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

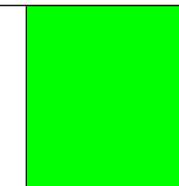
Residents' records reviewed showed that care plans are individualised based on a range of clinical information. InterRAI re-assessments and care plan evaluations are completed as per the schedules developed. Residents and families reported being informed and involved in care planning and evaluation and were very satisfied with the care provided.

The planned activity programme provides a variety of individual and group activities and residents can maintain links with the community. A vehicle is available to take residents to appointments and for outings.

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

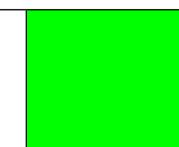
The foodservice meets the nutritional needs of the residents with special needs being catered for. Policies and procedures guide food service delivery, supported by staff with appropriate qualifications. The kitchen was well organised, clean and meets the food safety standards. Residents verified satisfaction 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.
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The facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan. Regular fire drills are conducted.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support a restraint free philosophy and safe use of enablers. No enablers or restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents and only undertaken in response to individual requests. Staff demonstrated a knowledge and understanding of the restraint and enabler processes.

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.
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Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked and results reported back to staff and management.

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	7	0	4	5	0	0
Criteria	0	30	0	3	6	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
<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>Deverton House Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code of Health and Disability Services Consumers' Rights (the Code). During interview, residents, family, and staff reported their understanding of the complaints process. All six residents and the two family members interviewed with the assistance of an independent interpreter confirmed they were aware of the complaints process and have no complaints. A complaint reporting form is available for residents in both English and Chinese. An annual audit is undertaken of the complaints systems and processes. This includes ensuring residents are aware of their right to complain. Information on the Code and independent advocacy services is displayed for all residents and family members in public areas as was verified by the interpreter.</p> <p>A complaints register is maintained and associated records verified complaints were investigated and responded to in a timely manner. Very few complaints are received. Three complaints received in 2017 were from one resident, who also complained via the District Health Board. The DHB advised in writing there were no substantiated findings. There have been no complaints to the Ministry of Health or Health and Disability Commissioner since the last audit.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. Residents and relatives who do not speak English are advised of the availability of an interpreter if required. The manager advises that a family member(s) normally speak English and</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>prefer to be utilised for communication with the residents; or alternatively, staff and the manager are able to converse with the resident and family in their own language. The manager notes if the resident is attending health appointments offsite, the owner/director often accompanies the resident. The owner/director was present during the unannounced surveillance to accompany a resident to a DHB appointment. Where applicable, the DHB is informed and independent interpreters are utilised.</p> <p>The general practitioner who provides clinical care for most residents speaks both Cantonese and Mandarin and can communicate directly with residents and family where applicable.</p> <p>Two family members of residents that were unable to effectively communicate in English expressed satisfaction with staff and their family member's communication processes. Staff interviewed identified they can effectively communicate with the residents via simple phrases and actions.</p> <p>Two family members interviewed confirmed that they were kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. There are two different family communication records in use in the clients' files, and some communication is noted to have occurred on the incident forms. Streamlining the process of recording family communications is included in the area for improvement raised in criterion 1.3.3.3.</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>PA Low</p>	<p>Deverton House Rest Home has a documented mission statement, philosophy and values that are focused around the provision of individualised, quality care in a homely, friendly environment. Monitoring of progress occurs via feedback with residents and family members, and via the quality and risk programme.</p> <p>Since the last audit there has been some refurbishment of the facility. New flooring has been placed in the lounge areas. The two lounge areas have been painted. Some of the bedrooms have been repainted. This aligns with the facility's goals.</p> <p>The service provides aged residential rest home level care via contract with Waitemata District Health Board. This is the only contract sighted. The facility manager advised all residents have been needs assessed as requiring rest home level care. All residents are aged over 65 years, and receiving ongoing care. There are no borders, no residents receiving respite services or day care services. Dispensation had been given in January 2018 for the provision of hospital level care for a resident for up to one month. The resident has since been transferred to another facility for ongoing hospital level care. The quarterly quality and service review meetings include discussions on any resident that has multiple falls. This is noted as one of the considerations as to whether the resident needs review of their assessed level of care.</p> <p>Clarity is required around whether the facility manager or the register nurse clinical nurse manager is overall responsible for ensuring the day to day care needs of the residents are met.</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>PA Low</p>	<p>Deverton House Rest Home has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, infection control data collection and management, and complaints management. There is a non-use of restraint policy. Regular internal audits are scheduled. A random review of five completed audits demonstrated a high level of compliance with organisation policy. The majority of audits are undertaken by the facility manager using templated audit tools. The medication audit was conducted by the previous RN and the facility manager. The audit of clinical records was undertaken only by the facility manager who does not have clinical knowledge to accurately complete the audit requirements. This is included in the area for improvement raised in criterion 1.2.8.1. An annual review of the falls prevention programme and restraint minimisation programme has been undertaken in January 2018.</p> <p>Where an issue or deficit is found, a corrective action is put in place to address the situation for the results of the internal audits, satisfaction survey, and maintenance requests. Corrective actions are developed and implemented. Short term care plans are not consistently developed following an incident. Refer to 1.3.8.3</p> <p>Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of each meeting were available for staff. Staff interviewed verified they are kept well informed of relevant quality and risk information. In addition, formal quality and service review meetings are held three monthly held with the facility manager, RN and the owner/director. These included discussion and analysis of quality and risk issues.</p> <p>Meetings are held every month with residents to obtain resident feedback on services, food, and activities as well as obtain information for future planning. Discussions occur on topical issues. The minutes of the last three meetings were sighted for residents, along with the results of the recent resident satisfaction survey. The feedback from residents in the satisfaction survey was very positive.</p> <p>Policies and procedures were readily available for staff. Policies have been developed by an external consultant and were dated January 2018. These have been localised to reflect the needs and names of managers working in Deverton House Rest Home. One paper copy of policies is available for staff. The facility manager and RN/CNM are responsible for document control processes.</p> <p>Staff, resident and family members interviewed expressed a high level of satisfaction about the services provided at Deverton House Rest Home.</p> <p>Organisation risks are documented and reviewed. The hazard register was most recently reviewed in January 2018. The shortfall from the last audit has been addressed. A number of potential hazards were observed during audit and a new area for improvement has been identified.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during</p>

<p>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>orientation and as a component of the ongoing education programme.</p> <p>Applicable events are being reported in a timely manner and disclosed to the resident and or designated next of kin. This was verified by residents and a family member interviewed. There are several areas where staff can document these communications. Refer to criterion 1.3.3.3.</p> <p>A review of reported events including falls, challenging behaviour, and manual handling (bruising) and one episode of lost medication, demonstrated that incident reports are completed, investigated and responded to. For the patient audited using tracer methodology interventions following a fall did not include neurological monitoring and evidence that the GP was informed in a timely manner; these are areas for improvement raised in criterion 1.3.3.3. Changes are not always made to the resident's long term care plan, or a short term care plan developed where necessary. This is included in the area for improvement raised in criterion 1.3.8.3. Staff communicated incidents and events to oncoming staff via the shift handover and via notes in the staff communication book. Incidents / events were also discussed with staff at the staff meetings and this included discussion on prevention strategies.</p> <p>Incidents are benchmarked with other aged residential care facilities. The benchmarking data was sighted, with data entered on line corresponding to the sampled reported events. Graphs are used to identify how Deverton House Rest Home compares with other facilities. Deverton House Rest Home is well positioned and under the threshold targets for each category of sampled events. Discussion of incident rates and trends occurs at the quarterly quality and service review meetings.</p> <p>The RN/CNM and the facility manager were able to identify the type of events that require essential notification.</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>PA Low</p>	<p>Copies of the annual practising certificates (APCs) were sighted for the two general practitioners (GPs), four pharmacists, and the RN/CNM.</p> <p>The personnel files of the facility manager and six staff were reviewed. Recruitment processes includes completing an application form, conducting interviews, reference checks, and police vetting. Staff have a job description on file. The job description / employment contract or confidentiality statement advises staff of privacy / confidentiality requirements. Annual performance appraisals have not occurred in the applicable staff files sampled. This is a new area requiring improvement.</p> <p>New employees are required to complete an orientation programme relevant to their role. A workbook is utilised to ensure all required topics are included. New employees are buddied with senior staff for several shifts until the new employee is able to safely work on their own.</p> <p>A staff education programme is in place with in-service education provided monthly. The topics are scheduled over a two-year period and align with Deverton House Rest Home's contract with Waitemata District Health Board (WDHB). Education provided in 2017 and 2018 includes (but is not limited to); fire safety, abuse and neglect, emergency events, advocacy services, the Code of Rights, and cultural safety / Treaty of Waitangi, aging,</p>

		<p>recognising sepsis, managing challenging behaviour and first aid. Staff can also attend relevant external education. Records of education are maintained and copies of some education certificates are present in the staff files reviewed. Some of the education is provided by the WDHB gerontology nurse specialists (GNS), the Deverton House RN, and another external provider via an online education programme and associated questionnaires.</p> <p>In addition, there is a competency assessment programme which requires care staff to demonstrate competency annually for activities including medication management (theory and practical), nebulisers, insulin, shaving, hand hygiene, weighing a resident, managing skin tears, undertaking oral hygiene, blood glucose testing and use of essential clinical equipment/vital sign monitoring. A competency list is maintained. All caregivers on the roster have completed all required competencies and records demonstrating / verifying each competency assessment have been retained and were sighted. The RN has undertaken the medicine and essential equipment/vital sign competencies. The facility manager, once assessed as competent, has undertaken assessment of some caregivers for competencies including shaving and oral cares.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract with Waitemata District Health Board (WDHB). There are occasions where staff are being rostered to work two shifts on the same day. Clinically based audits are not consistently undertaken by the registered nurse.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A system for medicine management using an electronic system was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the clinical nurse manager against the prescription. All medications were within current use by dates. Clinical pharmacist input is provided on request. The general practitioner interviewed stated there have been no issues requiring his input since the electronic system was implemented. There are no controlled drugs stored on the premises. Most medications are stored in a locked cupboard and the room is locked, with the exception of</p>

		<p>unused / unrequired medications and eye drops were not appropriately stored / secured.</p> <p>Electronic prescribing includes the name of the GP, the date of the last medication review, photo identification and date when the photograph was taken of the resident. Any allergies are clearly documented in red ink on the profile page or 'nil known' is documented to verify the resident/family has been asked about allergies and/or sensitivities.</p> <p>There are four residents who self-administer their own eye drops. Appropriate processes are in place to ensure this is managed in a safe manner (with the exception of the storage of the eye drops as noted above).</p> <p>Medication errors are reported to the clinical nurse manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process to analysis any medication errors, and compliance with this process was verified.</p> <p>The area requiring improvement in relation to the registered nurse completing a medication competency/peer review from the previous audit (1.3.12.3) has been effectively addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The foodservice is provided by two qualified chefs who job share the position. The chef interviewed has been in the role for three and a half years. The food service is in line with recognised nutritional guidelines for older people. The menu (that includes meals appropriate for Asian residents) has been reviewed by a qualified dietitian within the last two years. The few recommendations provided have been implemented.</p> <p>All aspects of food procurement, production, reparation, storage, transportation, delivery and disposal comply with current legislation and guidelines for older people. The service is working towards an approved food safety plan. Food temperatures and fridge/freezers are also monitored daily. The food service manager/chef has undertaken a formal qualification inclusive of a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal preferences, and any special dietary needs are identified, communicated to the chef and accommodated. There is only one resident who is a New Zealander, all remaining residents are Chinese, and all were observed eating their main meal at lunchtime with no assistance. Chop sticks were used by residents and cutlery was provided for the one non-Chinese resident to use who also enjoys Asian food.</p> <p>Evidence of resident satisfaction with meals was verified by resident/family interviews (a group of residents was interviewed and one other resident) and review of the minutes of residents' meetings held. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion. Residents confirmed they were very satisfied with food choices and the quantity of food available. There was sufficient staff on duty in the dining room at meal times to ensure appropriate assistance was available to residents if needed.</p>
Standard 1.3.6:	PA	Residents` records were randomly selected for review. The care plans reviewed were developed and implemented

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>from the initial nursing assessment and initial pre-admission information provided by a registered nurse. There is no registered nurse qualified presently to complete interRAI assessments. The RN/CNM is currently undertaking the required training for undertaking interRAI assessments.</p> <p>A range of equipment and resources was available, suited to the level of care provided in accordance with the resident's needs and as per the ARRC agreement requirements. All residents require rest home level care. There is an area of improvement identified in relation to ensuring care plans are updated and include changes to interventions as required / determined following interRAI and other assessments undertaken.</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>PA Low</p>	<p>The activities programme is provided by the facility manager. No staff have participated in any relevant activities training on the responsibilities associated with facilitating the activities programme. The programme is documented as being the same each month. The daily and weekly programme is documented on the whiteboard at reception in both English and Chinese. Photos are displayed on the wall of recent events celebrated. The facility manager and staff implement the programme. Outings and links with the community are encouraged that are meaningful to the residents. A church service is held regularly, or some residents attend a local church service. A social history and assessment is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Residents interviewed were happy and enjoyed the outings provided. Family interviewed are able to visit and participate by taking their relative on outings or to their homes. Independence is encouraged. The lead auditor sighted minutes of monthly residents' meetings which included discussion on the activity programme and outings.</p> <p>Other areas were identified as requiring improvement including supervision of activities, and ensuring activities plans are sufficiently detailed, individual goals are identified, and evaluated to ensure the resident's recreational needs are being met.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>The residents' records were reviewed, care plans sighted and progress notes, both nursing and medical, reviewed. Care plan evaluations and interRAI reassessments are planned six monthly according to a schedule (as sighted in the nurses/manager's office). The policy states that the care plan is reviewed if a change occurs in the resident's condition/health status or if they have an adverse event or an issue to be addressed (eg, wound care, pressure injury, sprain, fall or sustain an injury). Short term care plans are to be developed if and when an issue arises. While evaluations of resident's progress towards meeting their desired outcomes/goals are occurring at least six monthly, the resulting information is not being used to inform updated care plans. This is raised as an area for improvement in criterion 1.3.6.2. Short term care plans have not been developed or the long term care plans consistently reviewed when required.</p> <p>Family interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility has a current building warrant of fitness with an expiry of 27 July 2018. No changes have occurred to the facility with the exception of some renovation / refurbishment activities in bedrooms when they become vacant and the two lounge areas. The fire evacuation plan has not required amendment. Six monthly fire drills are conducted by an external consultant. Clinical equipment has evidence of current performance monitoring.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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 skin conditions. When an infection is identified, a record of this is documented on the resident infection incident log 2018. Any specimens sent to the laboratory are reported on by the laboratory utilised on a monthly printout. Any antibiotics are recorded as well on the print out reviewed. The clinical nurse manager is the infection control coordinator. Monthly surveillance data is sent through by the facility manager to a contracted provider who analyses, benchmarks and graphs the information. The information is sent back to the service provider to report to staff at the staff meetings. Infection rates and risks are low at this aged care facility. Surveillance undertaken is appropriate for the size and nature of the service provided.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards. The service has a restraint free philosophy. The definitions of restraint and enablers align with the standards. The restraint coordinator (the RN/CNM) provides support and oversight for enabler and restraint minimisation processes, and demonstrated a sound understanding of the organisation's policies, procedures and practice, and the restraint minimisation coordinator role and responsibilities. Caregivers interviewed could describe enablers and restraints and verified these have not been used 'for some time'.</p> <p>On the day of audit, no residents were using either restraints or enablers.</p> <p>Staff have been provided with orientation and ongoing training on restraint minimisation and enabler use. In-service education occurred in November 2016 attended by 12 staff. This topic is rescheduled on the 2018 education calendar. Training was undertaken in July 2017 on managing challenging behaviours. Six staff attended. The shortfall from the last audit has been addressed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	<p>A facility manager is employed at Deverton House Rest Home. Some of her responsibilities included facilitating the activities programme. The owner/director advises the facility manager is responsible for ensuring the day to day wellbeing and care needs of the residents are met. The facility manager verified understanding of her responsibilities and has completed a 'Diploma in healthcare management' (level 6 on the NZQA framework). The associated job description is not present in the facility manager's personal file, although the facility manager reports there is one. HealthCERT was notified of the facility manager being the manager of the facility on 10 October 2016. The facility manager has attended more than eight hours of education a year related to managing a residential aged care facility as required by the provider's contract with Waitemata District Health Board (WDHB). The facility manager monitors the progress in achieving goals via day to day activities, resident / family feedback and monitoring of the results of quality and risk activities. The owner / director confirmed having regular</p>	<p>The facility manager does not have a job description in her personal file although notes being responsible for ensuring the day to day care needs of the residents are met.</p> <p>The registered nurse was notified to HealthCERT as being the Clinical Care Manager in December 2017.</p>	<p>Ensure the roles and responsibilities of the facility manager and clinical manager or registered nurse are clearly defined, and HealthCERT are notified of who is responsible for ensuring the day to day needs of residents are</p>

		<p>conversations with the facility manager on residents' needs, business and quality and risk activities.</p> <p>An experienced registered nurse (RN) was employed in December 2017 and is responsible for clinical services, as the RN / charge nurse manager (CNM). She works at least 40 hours a week between the two rest homes owned by the owner / director. Prior to this, the RN/CNM provided the owner/director with RN advisory/consultancy services. The days and hours the RN works on site varies from week to week but are recorded on the roster. The RN/CNM is on call at all times when not on site. The RN/CNM has a current annual practising certificate (APC) and is working to complete her interRAI competency requirements. The previous RN (with interRAI competency) was reported to work at Deverton House Rest Home until February 2018. A notification was made to HealthCERT on 15 December 2017 that the clinical nurse manager is responsible for managing the service and ensuring the day to day care needs of the residents are met. The current job description on file is that of a registered nurse.</p> <p>The CNM/RN advises being responsible for the clinical care needs of the residents. The facility manager is responsible for other activities including facility management and day to day activities.</p>	<p>The current job description on file is for a registered nurse.</p>	<p>being met.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the</p>	<p>PA Moderate</p>	<p>Actual and potential risks are identified in the business continuity and risk plan. These are dated as reviewed by the facility manager in January 2018. The content includes identification of at least 21 potential risks and details corresponding risk reduction activities. Readiness and recovery steps are also detailed.</p> <p>A process is in place to report new hazards and maintenance requests. All reported issues had been followed up and addressed by one of the owners (who is responsible for maintenance) promptly. Staff reported maintenance issues are promptly addressed. The hazard register sighted was dated as reviewed in January 2018 and detailed a range of facility hazards using both words and diagrams. This now meets the standards.</p> <p>Several hazards were sighted during audit including a wet floor,</p>	<p>It was identified during audit that:</p> <p>The sluice room has key pad access but was open for the duration of the audit. Chemicals were present.</p> <p>The fire evacuation exit had obstacles (two portable clothes racks)</p>	<p>Ensure all hazards/risks are reported and managed in a timely manner.</p> <p>90 days</p>

<p>severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>unsecured chemicals, partially obstructed fire evacuation egress, uneven cobblestone pathway, furniture with rusty areas and rough surfaces on the deck handrail (by the dining room).</p>	<p>partially obstructing the egress. The ramp progresses to an uneven cobbled pathway.</p> <p>The top of the handrail on the deck needs repair. This is rusty and has some sharp edges that may cause unintentional injury.</p> <p>The dining room floor had been mopped. The floor was visibly wet and the 'hazard wet floor' sign was not initially displayed alerting staff and residents.</p> <p>The dining room furniture had rusty areas on the legs of the chairs and tables.</p>	
<p>Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of</p>	<p>PA Low</p>	<p>Staff annual performance appraisals have not been undertaken. The most recent appraisals in sampled files are dated June to August 2016 or have not been completed. A schedule of when appraisals are due has not been developed.</p>	<p>None of the five staff and manager files reviewed (of staff employed for more than 12</p>	<p>Ensure the annual staff performance appraisal process is</p>

consumers.			months) contained a performance appraisal completed in the preceding 12 months. There is currently no system in place to identify when staff are due their annual appraisal.	implemented and records are retained and maintained. 180 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>The rosters were reviewed for the period 5th March 2018 to 1 April 2018. These demonstrated that there is a RN/CNM on duty between two and four days each week. The RN hours varied between 15 hours and 32 hours on site each week. The RN/CNM is working to complete her interRAI competency requirements (refer to 1.3.6).</p> <p>The facility manager is on site weekdays 9 am to 5 pm and responsibilities includes facilitating the activities programme. The manager has also been rostered every weekend to cover laundry and kitchen hand duties on the rosters sighted. All other staff have at least one rostered day off each week.</p> <p>The manager and the RN are on call when not on site. This was verified by interview with the RN, manager and caregivers interviewed.</p> <p>One caregiver works 7am to 3pm, 3pm to 12 pm, and 12 pm to 8 am shifts. A support worker is rostered to work 3 pm to 8.30 pm and responsibilities are reported to include assisting with the evening meal.</p> <p>A cook is rostered on duty 6.30 am to 2 pm seven days a week.</p> <p>A cleaner is rostered 8.30 am to 1.30 pm Monday to Friday.</p> <p>A laundry / kitchen hand is rostered 8.30 am to 1.30 pm seven</p>	<p>There are reported to be three staff on leave at the time of the audit. There are three to five days a week in the four weeks of rosters sighted where staff have been rostered to undertake two different shifts in the same day. The facility manager is working week days as the facility manager then working the weekends in the laundry and kitchen hand role each week.</p> <p>The clinical records audit that evaluates the</p>	<p>Annual leave is planned to ensure safe staffing can be rostered and provided.</p> <p>Ensure clinical audits are undertaken by the registered nurse.</p> <p>90 days</p>

		<p>days a week.</p> <p>The facility manager advises there are three staff currently on leave, with two staff on 8-12 weeks leave. One caregiver has worked a small number of shifts at the other rest home owned by the owners. This has resulted in some staff being rostered to work two shifts in a day. This has occurred between three and five days in each of the four weeks rosters sighted. There is a gap between 1.5 hours and eight hours between these double shifts which involves a caregiver coming back for a second caregiving shift on the same day, or the weekend cook also doing the support worker shift each weekend day, or the laundry/kitchen hand also undertaking the support worker shift.</p> <p>A staff member with a current first aid certificate is on duty at all times. The manager advised that additional staff hours would be allocated to meet the care needs of the residents if required.</p> <p>Residents and the family member interviewed confirmed their personal and other care needs are being well met.</p> <p>The two owners assist with taking residents to offsite appointments and undertaking maintenance.</p> <p>There is an internal audit process for auditing care plans and clinical care as per the ARRC agreement. However, the residents' file audit had not been completed by a staff member with clinical knowledge and understanding.</p>	<p>contents of risk assessment, care plans and evaluations was undertaken by the facility manager who is not a registered nurse.</p>	
<p>Criterion 1.3.12.1</p> <p>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</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management to guide staff. Staff interviewed had a good understanding of medicine management. The senior caregiver observed administering medicines had completed a medication competency. Medicines are stored securely in a locked cabinet and room with two exceptions noted. Eyes drops for residents are being stored in the food fridge in the sunroom lounge which is accessible to residents. A new resident was admitted with a quantity of medicines and supplements. Staff were going to be returned to pharmacy as were no longer required. The size of the</p>	<p>A quantity of resident medicines and supplements for return to pharmacy was not stored securely.</p> <p>There is a number of residents' eye medicines that are not appropriately</p>	<p>Ensure all medicines are stored securely and appropriately and unwanted medicines are disposed of safely.</p>

guidelines.		bag and contents did not fit within the medicine cupboard. Staff had placed these items in a drawer in the staff / office kitchenette as in interim measure.	stored / secured.	90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>Each stage of service provision was reviewed in sample of residents` records. The records were not easy to follow through as there was a lot of content in each record sighted. The files sampled contained multiple copies of assessments and care plans making it difficult to identify what documents were current. There was no consistent archiving process evident.</p> <p>The residents` long-term care plans were reviewed. The care plan and interRAI schedules were displayed in the nurses`/manager`s office. Medical reviews and documentation was also reviewed. The dates for assessments were not able to be consistently confirmed with the timeframes allocated on the schedules. InterRAI dates evidenced the care plans were reviewed prior to the interRAI reassessments being undertaken (refer to criterion 1.3.6.1). The previous registered nurse who resigned in February 2018 had developed and implemented all of the care plans and associated documents that were reviewed in the files selected. A registered nurse / clinical nurse manager has been employed to cover the two aged care sites owned by the organisation.</p> <p>Timeframes for the general practitioner (GP) assessment after admission was met as per the contract obligation within 48 hours of admission. Reviews by the GP were undertaken three monthly and/or earlier if required. The resident`s file, who was audited using tracer methodology did not evidence the GP had been informed of an incident (an unwitnessed fall resulting in an injury to the head) in a timely manner. Neurological observations had not been undertaken. There was no documentation in the medical progress records about this incident. In three residents` files sampled, reported incidents (eg, falls) are not clearly referenced / evaluated or noted as being known of or reviewed by the GP during the routine reviews.</p> <p>The list of medical problems on the medical record is not dated or</p>	<p>There is no evidence in a resident`s file to demonstrate the general practitioner was notified of an incident. The resident had a fall and sustained an injury to the head. Neurological observations had not been initiated and a post falls reassessment had not been completed.</p> <p>There is no clear process that demonstrates that incident related information (eg, falls) is being communicated and evaluated during residents` routine GP reviews.</p> <p>There are multiple copies of resident assessments in the residents`</p>	<p>Residents` records demonstrate that the general practitioner is informed of adverse events in a timely manner, and staff undertake appropriate interventions for reported events. Ensure reported events (eg, falls) are evaluated during GP routine reviews.</p> <p>A process is implemented to ensure only current / relevant documents are in the residents` files.</p> <p>There is a consistent process in place to record communications</p>

		<p>signed off on admission or updated if another medical issue is identified. Some records, such as weight records and the routine monthly observations, only have the month the weight or vital signs were taken not the actual date.</p> <p>There are multiple areas in the residents' records to document communications with the resident's family, making it difficult to easily identify and track what communication has occurred with family, about what, by whom and when.</p> <p>Letters were sighted from external organisations/agencies in the sampled files (eg, from Work and Income, the Needs Assessment Services, and DHB outpatient services). A response was required to a letter from Work and Income for the resident audited using tracer methodology. However, there is no evidence that a response occurred.</p>	<p>records making it challenging to identify what are the current documents to enable follow through.</p> <p>There are multiple areas in the residents' records to document communications with the resident's family making it difficult to easily identify and track what communication has occurred.</p> <p>A response to an external letter was not present in a sampled file.</p>	<p>with residents and families.</p> <p>Ensure the dates when vital signs and weights are obtained are documented.</p> <p>Ensure responses to external communications are present in residents' files.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Information obtained from the interRAI and other assessments are not utilised to update the care plan interventions, in order to ensure the identified needs and/or goals are being effectively met. The care plans evaluation dates documented are not consistently evidencing that they have been evaluated after the re-assessment interRAI has been completed. Caregivers interviewed were satisfied that they were informed of any changes required in residents' care needs in a timely manner via shift handover, staff meetings and the communication book. Family members also identified they were informed in a timely manner when a resident's care needs changed (refer to 1.3.3.3).</p>	<p>Changes in interventions required are not updated in the care plans following the interRAI reassessment and care plan evaluations.</p>	<p>Ensure the interventions required in individual resident's care plans are updated to include changes resulting from the interRAI assessment and other</p>

		Appropriate interventions were not undertaken for a resident following a fall. This is raised as an area for improvement in criterion 1.3.3.3.		assessments. 90 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>Activities are planned monthly for the residents. Residents interviewed in a group with an interpreter stated they enjoyed the programme and meeting other residents. Activities are provided that are meaningful to the residents. Family members also commented that they are welcome to participate and that special events are held during the year and most recently for the Chinese New Year. The activities records were reviewed in the residents' files. There were a variety of activities forms utilised. Minimal information was available on some of the records sighted. Activities plans were not documented with identified individual goals for the residents as stated on the form used, nor were they linked to the long term care plan.</p> <p>A resident was observed to be leading an exercise activity in the dining room. The resident interviewed was happy to facilitate this aspect of the activities programme and reporting doing so on a regular basis. A staff member was not overseeing this activity in progress. The facility manager advised she normally oversees the activities programme but was otherwise busy with the audit.</p> <p>The facility manager is responsible for overseeing the activities programme. The facilities manager advised she had not been provided with any specific training on the responsibilities associated with overseeing the activities programme and maintaining the associated documentation.</p>	<p>Individual resident's activities plans are not well documented, or linked to the long term care plan, or goal focused.</p> <p>It was unable to be evidenced that the activities goals have been reviewed / evaluated or how this review occurs.</p> <p>A resident was observed to be leading an activity. A staff member was not overseeing the activity in progress.</p> <p>Staff facilitating the activities programme have not been provided with appropriate training.</p>	<p>Ensure that activities are planned to meet residents' assessed needs and goals, and that the programme is evaluated in a timely manner. Ensure activities are appropriately supervised and facilitated by an appropriately trained staff member.</p> <p>180 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>Resident records were reviewed. Two of five residents had experienced a change or incident that was different from expected. For example, the resident audited using tracer methodology had an unwitnessed fall and injury to the head, and another resident had experienced several falls. Repeat falls assessments had not undertaken. The care plans had not been updated or a short term care plan developed to address the issues raised. The family were notified but this information was recorded on two different forms that are currently utilised in the resident's individual records. One is a family contact record and the other a family communication record. Family interviewed were able to verify that they were informed if any changes occurred for their relative (refer to CAR at 1.3.3.3).</p>	<p>When progress is different from expected, the service does not evidence consistently that repeat falls risk assessments are completed, the long term care plans are updated to reflect the changes that have occurred or that a short term care plan has been developed until the issue has resolved.</p>	<p>Ensure falls risk assessments are conducted following a fall, and a short term care plan is developed when a resident's progress changes and that the long term care plan is updated as required.</p> <p>90 days</p>
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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.

No data to display

End of the report.