

Logan Samuel Limited - Anne Maree Court

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:

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| Legal entity: | Logan Samuel Limited |
| Premises audited: | Anne Maree Court |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical |
| Dates of audit: | Start date: 19 April 2018 End date: 20 April 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: | 52 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

| Indicator | Description | Definition |
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| | 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

Ann Maree Court provides residential rest home and hospital level care for up to 57 residents. The service is operated by Logan Samuel Limited and managed by a registered nurse/facility manager, with support from the owner, a general manager and a clinical nurse leader.

The most significant changes to the service and facilities since the previous audit are a recent turnover of clinical staff, which left the facility with no interRAI certificated staff for a period. This is still being rectified, the new clinical nurse leader is undertaking training. The organisation has also introduced a new quality and risk system and installed a new kitchen and closed-circuit television monitoring.

Families spoke positively about the care and services provided; they particularly mentioned the lively atmosphere.

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, managers, staff, and a general practitioner.

The audit identified six areas requiring improvement relating to staffing, medicines, service delivery and restraint.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | 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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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. The staff mix reflects the resident population (for example, gender and nationality).

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | 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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. Medicines are managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Some standards applicable to this service partially attained and of low risk. |
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers in use at the time of audit. There was one resident using restraint (bed rails). Use of enablers is voluntary for the safety of residents in

response to individual requests. Staff demonstrated understanding of the restraint and enabler processes. Environmental restraint due to the front door having a key pad lock is safely managed by the service.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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 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) |
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| Standards | 0 | 44 | 0 | 4 | 2 | 0 | 0 |
| Criteria | 0 | 94 | 0 | 4 | 3 | 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) |
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| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The facility 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. A Code of Rights for residents is displayed in each resident's room.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>Nursing and care staff interviewed understood 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. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. The facility manager reported that five of 57 residents have an advance directive resuscitation form</p> |

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| | | signed by the GP. Staff were observed to gain consent for day to day care. |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical nurse leader was able to provide examples of when the facility would encourage the support and/or use of the advocacy service.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>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.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> |
| <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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 55 complaints have been received since the beginning of this year (2018) and 42 complaints between July and December 2017. A significant number of these have been initiated by the same family. The DHB have received and investigated two complaints from family members since the previous surveillance. The October 2016 complaint about the admission process and care was substantiated and the DHB signed off that the corrective actions taken had led to improvements. The other complaint received in November 2017 resulted in the service being required to review its complaints process. The complainant has continued to raise frequent complaints and many of these have not resulted in an agreed resolution. All actions and communications are</p> |

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| | | <p>documented.</p> <p>Written acknowledgement, investigations and responses are occurring within acceptable timeframes. Action plans show any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaint investigations from the Office of the Health and Disability Commissioner since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff. The Code is displayed in the main reception area together with information on advocacy services, how to make a complaint and feedback forms.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>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.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their</p> | FA | <p>Staff support residents in the service 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. There is a current Māori health plan developed</p> |

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| individual and cultural, values and beliefs. | | with input from cultural advisers acknowledging the four cornerstones of Maori Health which include Whanau (family health), Tinana (physical health), Hinengaro (mental health) and Wairua (spiritual health). There were no residents who affiliated with their Maori culture. Evidence of staff acknowledging and respecting the resident's individual cultural needs was integrated throughout the resident's care planning and activities. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The residents' and families interviewed confirmed that individual needs are being met. |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included</p> |

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| | | the knocking on residents' doors before entering and the day to day conversations between staff, residents' and families. |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There is one resident for whom English is their second language. Staff knew how to access interpreter services, although reported this was rarely required due to family members who are very supportive and available by phone. Staff know the residents well and are also able to provide interpretation as and when needed.</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> | FA | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. The owner/operator is often on site and kept updated, this was confirmed by interview. The owner is provided adequate information to monitor service performance emerging risks and issues.</p> <p>The service is managed by a RN facility manager (FM) who has been in the role for four years and holds relevant qualifications and a practising certificate. The manager's role, responsibilities and accountabilities are defined in the job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at external education sessions. A new general manager has been appointed to oversee Ann Maree Court and its 'sister' facility Anne Maree Gardens.</p> <p>Ann Maree Court holds contracts with Waitemata DHB for hospital and rest home care. On the days of audit there were 30 residents receiving hospital care and 22 assessed as rest home level care. One of these residents was receiving services on an interim care contract. The FM and owner/operator said there were no residents under 65 years of</p> |

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| | | age. |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>When the FM is absent, the owner/operator and general manager carry out all the required duties. During absences of key clinical staff, the clinical management is overseen by the FM or other delegated RNs who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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> | FA | <p>The organisation introduced a new quality and risk system in late 2017. The system is still being embedded, but this and the previous established systems and approaches reflect the principles of continuous quality improvement. Quality and risk includes collection and analysis of all incidents/accidents, infections, complaints, and regular resident and relative satisfaction surveys, internal audit activities and monitoring of outcomes and the implementation of corrective actions.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at a variety of staff meetings (for example, the monthly falls and restraint/quality meetings). Staff reported their involvement in quality and risk management activities through audit activities, attendance at meetings, handovers and reading of meeting minutes and memos. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager, general manager and owner described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. All senior management are familiar with the Health and Safety at Work Act (2015) and have</p> |

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| | | implemented requirements. |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | PA Low | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were detailed and complete, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner and staff at regular intervals.</p> <p>The facility manager, general manager and owner described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been two events that required police reporting and investigations; one for assault on a staff member by a relative and another related to the loss of controlled drugs. These ought to have been notified under section 31. There have been no coroner's inquests, issues-based audits or other notifications.</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> | FA | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of eight staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on 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. The facility manager is the internal assessor for the programme. There is only one trained and competent registered nurse (0.4 full time equivalent (FTE)) who undertakes interRAI assessments). The service had four RNs and the clinical nurse leader recently</p> |

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| | | resigned. Three of the new RNs including the Clinical Nurse Leader are in training with interRAI. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. |
| <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>There is a documented and implemented process for determining staff levels and skill mix 24 hours a day, seven days a week (24/7). The service adjusts staff numbers to meet the changing needs of residents. On the days of audit, the maximum number of staff were rostered on. (For example, one RN for each morning, afternoon and night shift, four caregivers in the morning, plus two short shift caregivers from 8 am -1 pm, four caregivers in the afternoon and two at night. The facility manager is also a RN and is on site Monday to Friday for 40 hours per week. This meets the requirements of the ARC contract, but evidence gathered on site suggests a review of staffing levels is required. The clinical nurse leader is on call 24/7 with the facility manager as back up. After hours calls do not happen often. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>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. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p> | <p>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 are provided with written information about the service and the admission</p> |

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| | | <p>process. The facility seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the 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. Service charges comply with contractual requirements. Improvements have been made to the admission process following a complaint.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed that all relevant documentation was provided and communication with the family was ongoing. Family of the resident reported being kept well informed during the transfer of their relative.</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> | PA Moderate | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management, however not all eye drops/ointments were dated when opened and medication was found on the bedside table of a resident in their room. All staff who administer medicines have been assessed as competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> |

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| | | <p>Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's 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 medicine chart. The facility manager reported that medication standing orders are now not used due to the implementation of the medication electronic system.</p> <p>There were two residents who were self-administering medications at the time of audit, however not all appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>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.</p> | <p>FA</p> | <p>The food service is provided on site by one of two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a four- week menu and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and has a grade pending certificate issued 15 January 2018 while awaiting inspection by the local council. The kitchen is part way through approved renovations in its development of an update. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> |

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| | | A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. All food is cooked on site and served to residents in the dining room adjoining the kitchen and the main residents lounge at two different sittings. There are 17 residents whom require support with feeding. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Interviews with residents and staff on the days of audit evidenced that not all residents' are satisfied with the support of staff at meal times and communication between staff (see criterion 1.2.8.1). |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is 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. There were not examples of this occurring discussed. There is a clause in the access agreement related to when a resident's placement can be terminated. |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | Information is documented using validated nursing assessment tools, such as, pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform initial care planning. For residents that are high risk of falling and/or have a memory impairment there are signs on residents' bedroom doors highlighting that the room has an intra bed exit sensor to detect motion. All residents are seen by the physiotherapist whom has developed a traffic light plan which acknowledges equipment required by the resident and how it is to be used and a supporting mobility support plan. Sighted also in multi-disciplinary meeting documents with families are evidence of discussions around falls and a request for the family to consider supporting consumables such as limb protectors. For residents whom are identified with weight loss (as seen in two of the resident files reviewed) care plans and assessment tools identified discussions with GP, food charts, weekly weights, supplemental nutrition and support from mental health services where appropriate. Staff interviewed knew the residents well and were able to discuss |

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| | | <p>individual residents and their specific behaviours and/or weight loss and interventions required. The sample of care plans reviewed had an integrated range of resident-related information. Currently there are three interRAI assessments in draft (but completed) awaiting sign off by the interRAI assessor supporting three registered nurses currently in training to be able complete interRAI assessments at the facility. All other interRAI assessments are complete and up to date for the remaining residents. The facility manager reported that he has interRAI manager access to support the new registered nurses due to four interRAI trained registered staff having left the facility in the last 12 months. Residents and families confirmed their involvement in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>For residents that present with challenging behaviours, care plans sighted documented specific behaviours and triggers for the resident and the different interventions that have been effective. On the day of audit there were several situations observed and heard by the auditors where the residents had escalated with their challenging behaviours, it was evident when the staff intervened that they knew the resident well and were able to de-escalate the situation/s at the time. Information about these events were documented in the residents' progress notes and incident form. These events were also discussed at handover of the following shift.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to</p> | PA Low | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's</p> |

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| <p>meet their assessed needs and desired outcomes.</p> | | <p>individualised needs was evident in all areas of service provision, however not all care plans developed and provided by an external source were followed. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in handover and documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activities programme is provided by a diversional therapist holding the national Certificate in Diversional Therapy and an assistant. The diversional therapist supports residents Monday to Friday from 9.00 am to 4.00 pm with support from an assistant Thursdays and Fridays, Saturday and Sundays.</p> <p>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 three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions with residents and at residents' meetings. The activities are varied and flexible and are modified to meet the capabilities of the individual residents and residents who present with challenging behaviours. Residents interviewed confirmed they find the programme interactive highlighting the group interactions.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as</p> |

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| | | clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', 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 the clinical nurse specialist regarding catheter care and mental health services for the older adult. The resident and the family/whānau 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.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. All staff who handle chemicals have been trained on safe chemical handling. 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.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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> | FA | <p>A current building warrant of fitness, expiry 06 November 2018, is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the</p> |

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| | | <p>environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>A closed circuit television system has been installed to enhance resident safety. Residents, their families and staff were consulted, and have consented to the use of this.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Staff confirmed they know the processes to follow when repairs or maintenance is required. Review of the maintenance request logs show that requests are actioned on the same day if possible. There have been issues with the responsiveness of maintenance but these are being addressed through performance management.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 31 rooms with toilet/shower ensuite, three with no ensuite and twenty three with a shared toilet. Communal toilets and showers are located within easy access. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Staff reported concerns about the size of two bedrooms but it was shown that the rooms could accommodate a hoist with two staff to assist. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>Mobility aids, walkers and wheel chairs are stored in one of the front lounges when not in use. This does not cause any impediment to egress.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p> | FA | <p>Communal areas are available for residents to engage in activities. The main lounge area is spacious and the majority of hospital residents stay there during the day for entertainment and meals. The designated dining room is on the opposite side of the facility which can be easily accessed by mobile residents or by cutting across the inner</p> |

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| needs. | | courtyard. There are two other lounges which are thoroughfares but provide alternate areas for visiting, if required. Furniture is appropriate to the setting and residents' needs. |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Laundry is now undertaken off site by a contracted provider. This has significantly reduced issues with lost or damaged laundry. Family interviewed reported the laundry is managed well and that clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have been employed for many years and are appropriately trained, as confirmed in interview of cleaning staff and training records. The cleaning store room is immaculate and orderly. Chemicals were stored in a safe and secure manner and decanted in to appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>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. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 14 April 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for a maximum 57 residents. Water storage tanks are located around the complex. There is no generator on site but hot water and heating can be produced by gas if necessary. Emergency lighting is regularly tested.</p> <p>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.</p> <p>Appropriate security arrangements are in place. Doors and windows</p> |

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| | | are locked at a predetermined time. |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by individual panel heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external sources as required. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and owner director and tabled at the infection control and staff meetings. This committee includes the clinical nurse leader, facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>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 responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The IPC coordinator is a newly graduated nurse and has appropriate skills, knowledge and qualifications for the role, and has been in this role for three months. She has undertaken online infection prevention and control training and is booked into external formal training in June 2018. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support</p> |

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| | | the programme and any outbreak of an infection. |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing.</p> <p>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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>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 during hot weather.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract (with or without a catheter) soft tissue/skin, gastro-intestinal and respiratory tract infection. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared at staff handovers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. For the period of November 2017 – March 2018 the facility recorded a total of 38 infections, five of those residents</p> |

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| | | <p>with a combined total of 16 infections were identified as requiring frequent antibiotics, and appropriate interventions in the residents' care plans were sighted to minimise and reduce the risk of infections.</p> <p>A summary report for a recent gastrointestinal infection outbreak in October 2017 was reviewed where 10 residents, four staff, one family member and two students were affected. The report demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and although they had a sound understanding of the organisation's policies, procedures and practice there were areas requiring improvement. In criterion 2.2.2.1 and 2.2.4.2</p> <p>On the day of audit, one resident had bed rails in place as a restraint when in bed for safety reason. There were no residents using enablers. There are several alternatives to restraint in use to prevent injury to residents. These include sensor mats, low beds and 'fall out' mats and the use of infra-red light beams to alert staff to movement in the resident's bedroom.</p> <p>The front door has a key pad lock for the safety of wandering resident. Competent residents were observed to be using the keypad to exit whenever they wanted, or staff at the front desk assisted them and visitors to open the door. This type of environmental restraint is openly acknowledged by the service and residents and/or their family/EPOA sign consent and agreement for this.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the falls/restraint group minutes, files reviewed, and from interviews with staff.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and</p> | FA | <p>The FM, Clinical Nurse Leader and GP are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of the falls and restraint group meeting minutes,</p> |

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| <p>procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | | <p>residents' files and interviews with the coordinator that there are clear lines of accountability. The service strives to keep restraint use to a minimum and has installed infra-red light beams in the bedrooms of eight residents who are at risk of falling. These alert staff to their movements at night. Other residents have sensor mats or low beds with fall out mattresses. Evidence of family/EPOA involvement in the decision making was on file of the resident who has bedrails in place. Consent was signed for on 12 September 2017. Use of a restraint is part of the plan of care.</p> |
| <p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | <p>PA Low</p> | <p>Policies stated that assessments for the use of restraint are to be documented. The FM/restraint coordinator interviewed knew what was required but could not recall carrying out an assessment and there was no documentation of this. The family/EPOA had signed for consent which evidenced involvement. The form was also signed off by the general practitioner. There is a requirement to complete assessments for all types of restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p> | <p>FA</p> | <p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and installation of infra-red laser beams).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained and reviewed at the monthly falls and restraint group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use.</p> |
| <p>Standard 2.2.4: Evaluation</p> | <p>PA Low</p> | <p>The individual use of restraint for the resident using bedrails has not been reviewed and evaluated since it was initiated seven months ago,</p> |

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| <p>Services evaluate all episodes of restraint.</p> | | <p>although it was part of the six-monthly care plan and interRAI reviews. Because there was no assessment for the use of restraint, there was no determination about the frequency of review.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>The falls/restraint /quality group meet monthly to discuss all restraint use which includes the requirements of this Standard. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, what alternatives to restraint are in use, the competency of staff and the appropriateness of restraint / enabler education. The annual internal audit that is carried out also informs these meetings. The last audit occurred before the implementation of the new quality system and restraint procedures. The change in restraint policy and processes was discussed at these meetings. Data reviewed, minutes and interviews confirmed that Ann Maree Court is well on its way to being a restraint free facility.</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) |
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| <p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p> | PA Low | The facility manager and the adverse events documents described two events that required police reporting and investigations (missing medication and assault). These types of situations are described as events that need to be reported according to the MoH reporting guidelines 2016. | The provider has not meet the requirements regarding essential notifications under Section 31 of the Health and Disability Services (Safety) Act 2001 which requires all certified providers to notify the Director General of Health. | <p>Ensure that events that require reporting under section 31 are notified.</p> <p>180 days</p> |
| <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> | PA Moderate | There has been a significant turnover of registered nurses (four plus the clinical nurse leader since Christmas). Recruitment and gaps in staffing because of maternity leave and other staff on leave has taken its toll. Ten care staff interviewed said they needed more staff, described their workloads as 'heavy' and felt | <p>The number of staff allocated does not appear to take into account:</p> <ul style="list-style-type: none"> - the layout of the facility. This is a large square with no observation points in corridors (although CCTV has been recently installed). Care staff were seldom seen in these areas although a large number of rest home residents were either in their rooms or | <p>Review the number of care staff and RNs on each shift considering the acuity, high dependency needs and challenging behaviour of residents, and the</p> |

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| | | <p>unable to complete the work allocated to them. The majority of hospital level care residents are two people assist and many of the rest home residents are mobile with challenging behaviour and confusion.</p> <p>The monthly falls incidents review form for February and March contained comments that falls might be due to low staffing.</p> <p>One resident with escalating and audible anger was unattended for 1.5 hours, until the auditor requested staff assistance because of the threat posed to property and other residents. Also see requirement in 1.3.6</p> <p>Observations on both days revealed insufficient staff in the dining room to support residents with their meals. There are 17 residents who require assistance with eating and drinking. The hospital residents were still being fed lunch at 2pm on day one. A resident in the dining room was fed their lunch too fast and the same spoon was used for the savoury and the sweet dish. At breakfast, one resident was observed to have fallen asleep without eating or drinking and was about to be moved out of the dining room, another resident was complaining they had not been served their breakfast. Kitchen staff reported that meals would often come back uneaten and that care staff mixed up who required special</p> | <p>wandering the corridors.</p> <p>- the high dependency needs of the majority of residents and the changing and challenging behaviour of others.</p> <p>The system for back filling unexpected staff absences is not reliable or efficient.</p> | <p>layout of the facility.</p> <p>Strengthen the system for back filling staff absences.</p> <p>30 days</p> |
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| | | <p>meals in their confusion of haste to get meals on the table.</p> <p>There was a problem finding replacement staff for an unexpected absence on day two of the audit. Although there are many 'casual' staff recorded as available on the roster, none contacted were willing to come in. It took until 10.30 am to find replacement staff.</p> <p>One resident described themselves as neglected and said they only saw the staff when they were escorted to the dining room for lunch. Staff interviewed stated the resident chose to isolate. This person needs assistance to mobilize due to sight impairment and became anxious that no one came to assist them to an appointment on day one of the audit.</p> <p>The rosters reviewed for the previous three months showed multiple changes.</p> <p>Family members were not concerned about staffing and the facility manager reviews call bell response times regularly to identify any issues.</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>Medication is administered by either a medication competent registered nurse or caregiver. A staff member observed at medication round demonstrated good knowledge and had a clear understanding of medicine management. When viewing the medication treatment</p> | <p>Medication administration processes were not undertaken in accordance with the organisational policy and good medication practice in relation to, the written acknowledgment of dates when medication (eye drops/ointments) are opened, documentation and follow-thru and/or outcomes of medication</p> | <p>Provide evidence that a safe medicines management system is implemented to comply with legislation and medication guidelines.</p> |

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| <p>guidelines.</p> | | <p>room/trolley the auditor found 13 eye drops/ointments of which nine of those 11 medications were opened but not dated when opened to ensure that the medication was used within the required timeframe stipulated on the medication. In viewing the medication electronic device over a 19-day period from the 1st March 2018 to the 19th March 2018 it was reported that 75 of the withheld/not administered medications had no reason written why (in the electronic device, progress notes and/or GP discussions/notes). When viewing the facility, an unidentified medication tablet was found on top of a resident's locker in their room (the resident was not self-medicating nor was the medication stored securely).</p> | <p>being either withheld or not administered by staff, and the administration of medication to individual residents.</p> | <p>30 days</p> |
| <p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.</p> | <p>PA Moderate</p> | <p>At the time of audit, two residents self-administering medications, did not have an assessment to demonstrate competence. The medications were not stored securely, nor could staff show evidence that residents were asked if they had taken their medications. In discussions with the clinical nurse leader, it was reported that he was not confident that the residents are competent in the self-administering of their medication due to the residents' medical history. The GP had completed three monthly reviews and the medication was prescribed.</p> | <p>The safe facilitation of two residents' who are self-administering medication was not evident.</p> | <p>To provide evidence that residents self-medicating comply with legislation and medication guidelines.</p> <p>30 days</p> |

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| <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 Low</p> | <p>A resident was admitted to the facility following discharge from hospital post-surgery. The resident required rehabilitation support prior to returning home. An external clinical nurse specialist created a specific and individual care plan identifying the issues that the resident has, required interventions and time frames that the staff of the facility are expected to follow. There were multiple instances where the nurse specialist's plan of care had not been followed including for example, vital signs not being completed as directed, a wound management plan had not been developed and wound evaluation was not occurring. In admitting the client, the registered nurse had developed another care plan, however the care plan did not reflect the client's required needs as specified by the nurse specialist and had another resident's name under one of the interventions. The clinical nurse leader interviewed reported that he was unaware that the facility did not need to develop a separate care plan. At the time of audit, the care staff reported that the client was well cared for, that they were aware of the initial care plan developed by the clinical nurse specialist and the interventions identified in the care plan are carried out as and when required.</p> <p>The resident with escalating anger is prone to periods of confusion and/or</p> | <p>The care plan developed by an external nurse specialist to support the resident while rehabilitating after an injury before returning home has not been followed to ensure that the individual needs of the resident were being met and the requests/instructions of the allied supporting staff were followed.</p> <p>A distressed and escalating (with anger) resident was unattended to for a period of time on day two of the audit. The interventions in the care plan were not being carried out.</p> | <p>To provide evidence that all interventions and evaluations are carried out in practice.</p> <p>180 days</p> |
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| | | delusion because of their medical condition. This person requires either reassessment or closer supervision. Refer corrective action in 1.2.8. | | |
| <p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p> | PA Low | <p>Care records for the resident with a restraint intervention (bed rails) did not contain an assessment for safe use of the restraint nor was there evidence that the intervention has been reviewed since it was initiated in September 2017. The FM concurred that a documented assessment had not occurred. Discussion revealed that as the bed rails were initiated at the request of family, and the staff were not familiar with the new forms and processes for assessing restraint. Observations of the resident, the monitoring records and the bedroom showed that attempts to minimise risk by use of a snake cushion, and bed rail covers were happening. There have been no adverse events as a result of the restraint.</p> | <p>There is no documented evidence that a resident with bedrails in use, had been assessed prior to initiating the restraint.</p> | <p>Ensure that all procedures related to the restraint process are adhered to.</p> <p>60 days</p> |

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| <p>Criterion 2.2.4.2</p> <p>Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.</p> | <p>PA Low</p> | <p>The care records for the resident using bedrails and minutes from the falls/restraint meetings did not describe any review or evaluation process. The FM/coordinator confirmed that review specific to the bedrails had not occurred. Policy and procedures and this standard require reviews of restraint interventions at a frequency determined by the degree of assessed risk.</p> | <p>There has not been a review of the restraint intervention since it was initiated in September 2017.</p> | <p>Ensure all restraint interventions are reviewed and evaluated at times intervals relevant to the degree of risk and type of restraint in place.</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.

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End of the report.