Selwyn Care Limited - Sprott House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Selwyn Care Limited
Premises audited:	Sprott House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 27 August 2018 End date: 28 August 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: 88

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.

General overview of the audit

Sprott House provides rest home, hospital and dementia level care for up to 97 residents. There were 88 residents on the day of the audit.

A provisional audit was conducted to assess a prospective new owner for Sprott House and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. The prospective owner was also interviewed.

Sprott House has a general manager who is responsible for operational management of the service. She is supported by a management team including a care manager, care coordinator, unit manager/lifestyle support manager, finance and administration manager, support services/village coordinator and a quality manager. Residents and family members interviewed spoke highly of the services provided at Sprott House.

The prospective owner was interviewed to establish preparedness in owning and operating Sprott House. The prospective owner (aged care organisation) currently has 10 care homes from Whangarei to Cambridge. The prospective owner advised that their quality systems and processes, and policies and procedures would transition over to Sprott House from 1 October 2018. The general manager will remain in the role to support the new owner on a fixed term contract. The prospective owner advised that rosters and staffing levels will transition to their staff policies and procedures from 1 October 2018.

There were no areas requiring improvement identified at this audit.

Consumer rights

Sprott House endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Staff demonstrated an understanding of residents' rights and obligations. Staff training is provided on resident rights including advocacy services. Written information regarding consumers' rights is provided to residents and families. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

Sprott House has a current business plan and a quality assurance and risk management programme that outlines objectives/goals. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to staff meetings and quality oversight meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Sprott House has job descriptions for all positions that include the role and

responsibilities of the position. There is a two-yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. Families and residents participate in the care planning and review process. The occupational therapist (lifestyle support manager) and recreation assistants provide an activities programme for the residents in the rest home, hospital and dementia care units. The programme is varied and interesting and meets the recreational needs and preferences of the consumer group. Medication policies reflect legislative requirements and guidelines. Medication management includes the use of an internet based electronic medication system. Registered nurses, enrolled nurses and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three monthly. An external contractor is contracted to provide the food service. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes and special dietary requirements are met. All meals are prepared on-site. There is dietitian review of the menu.

Safe and appropriate environment

The building holds a current warrant of fitness. There are adequate toilets and showers for all units. A number of resident rooms include single ensuites. Fixtures, fittings and floorings are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are done on-site and are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is available. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility is well laid out and the temperature is

comfortable and constant. Residents and family interviewed are very satisfied with the environment. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times.

Restraint minimisation and safe practice

Sprott House has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. At the time of the audit there were thirteen residents with restraints and one resident using an enabler. Resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three-monthly evaluations. Staff have received training on restraint minimisation. All restraint processes including required documentation is completed.

Infection prevention and control

The service has infection control policies and an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with 15 care staff, including ten caregivers, one care coordinator, three registered nurses (RN) and one enrolled nurse (EN), reflected their understanding of the key principles of the Code. The prospective owner currently has 10 care homes from Whangarei to Cambridge, and have policies and processes in place around the understanding of consumer rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	Sprott House has policies and procedures relating to informed consent and advanced directives. Ten files reviewed included signed informed consent forms for information sharing, ADLs, mobility assistance, displaying the resident name on their door, taking of photographs,

choices and give informed consent.		collecting health information and outings as part of the admission process and agreement. There is a resuscitation form and process. Resident files reviewed had completed resuscitation documentation. There were admission agreements sighted, which were signed by the resident or nominated representative. Discussion with families identified that the service actively involves them in decisions that affect their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held every three months. Quarterly seasonal newsletters are provided to residents and relatives.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The general manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Ten complaints have been received since the last audit. Documentation including follow-up letters and resolution demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed are followed-up and implemented. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care manager, clinical coordinator, RNs and ENs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Eight residents (six rest home and two hospital level) and four relatives (three hospital and one dementia care) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. Staff have received training around abuse and neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were no residents that identified as Māori living at the facility. Māori consultation is available through the documented iwi links and Mana Whenua, which is provided through Māori staff who are employed by the service. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. A formal quality improvement programme has been developed, which includes identification through to sign off. There is a two-yearly in-service training programme that has been implemented and staff are supported to undertake external training. Staff development occurs by way of education and in-service training. The general manager, care manager, clinical coordinator and unit manager/lifestyle support manager attend training sessions appropriate for their positions. Care staff are supported to complete a literacy programme and Careerforce aged care qualifications. Services are provided at Sprott House that adhere to the Health and Disability Sector Standards. There is an implemented quality improvement programme that includes performance monitoring. There are implemented competencies for caregivers, RNs and ENs. There are clear ethical and

		professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fourteen accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. An introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Sprott Care Limited (Sprott House) provides rest home, hospital and dementia level care for up to 97 residents. Seventy-three beds are dual-purpose rest home/hospital level. The dementia care unit currently has 24 beds, one further room has not yet been converted into a resident room. On the day of audit, there were 88 residents in total, 40 rest home residents including one resident on respite care, 24 hospital residents and 24 residents in the dementia care unit. All residents were under the age related residential care (ARRC) agreement. Sprott House Trust is a not-for-profit organisation governed by a board of trustees. Sprott Care Limited is incorporated as the Trusts operating company. Sprott House Trust and Sprott Care Limited, taken together, are a charitable institution with a continued focus on aged care. The trustees employ a general manager, who is the director of Sprott Care Limited and is responsible for the operation of the residential service and the 13 villas on-site. The general manager attends board meetings and

		provides management and clinical information to the board of trustees. There is a strategic and business plan covering 2016 to 2019, which identifies the philosophy of care, mission statement and business objectives/goals and the values of the trust and the risks identified by the management team and the board. The board of directors, general manager and management team review the strategic and business plans as required, and the quality risk management plan 2017- 2020 annually (the 2018 review for 2017 was sighted). This provisional audit included an interview with the prospective owner. The prospective owner already provides aged care services across 10 care homes from Whangarei to Cambridge. The prospective owner/organisation advised that their policies and procedures will transition over to Sprott House from 1 October 2018, when the sale is completed. The general manager will remain in the role to support the new owner on a fixed term contract. The prospective owner has an organisation five-year strategic plan 2018 - 2022. A site-specific business plan 2018 - 2022 will be introduced for Sprott House and will be reviewed six monthly. The general manager has been with the service nine years and is supported by a finance and administration manager, support services/village coordinator, financial administrator and a quality manager. The general manager is also supported by a care manager and care coordinator, and a unit manager/lifestyle support manager. The general manager has maintained at least eight hours annually of professional development related to managing a rest home/hospital/dementia care service.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The care manager steps in when the general manager is absent. The care manager is supported by the care coordinator, unit manager/lifestyle support manager, quality manager, support services/village coordinator, and the finance and administration manager. The same process will continue with change of ownership.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The service has a quality risk management plan in place that is reviewed annually. Quality and risk performance is reported across the facility meetings and also to the Trust Board. Facility meetings include full facility (staff), management, quality oversight, clinical, health and safety/infection control and wing meetings. Meeting minutes sighted evidence there is discussion around quality. Staff interviewed confirmed that they are well informed and have ready access to meeting minutes. The general manager reports monthly to the board of trustees. This provide a coordinated process between service level and organisation. There are monthly accident/incident benchmarking reports completed by the quality manager that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. There is an internal audit programme. Audit summaries and action plans are completed where a non-compliance is identified. Resident/family meetings occur three monthly and the residents and family members interviewed confirmed this. Residents/relatives are surveyed annually to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The result for the family/whānau satisfaction survey completed in October 2018 was at 93% overall satisfaction and the resident satisfaction survey was at 85%. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the monthly health and safety committee meeting. The health and safety officer (quality manager) has completed external health and safety training and attends the district health board (DHB) risk management group meetings. Each wing has two health and safety representatives. All representatives have attended health and safety training. The health and safety committee meet three-monthly. The meeting minutes evidence trends and analysis of accidents/incidents. The hazard register is up-to-date. The health and safety policies have been reviewed to reflect current legislation. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of

		interventions on a case-by-case basis to minimise future falls. The prospective owner advised that their organisational quality systems and processes, and policies and procedures would transition over to Sprott House from 1 October 2018 and that there should not be any issues with continuity in this area.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an accident/incident policy, which is part of the risk management and health and safety framework. The service collects incident and accident data and reports monthly to the health and safety officer, clinical meetings and the three-monthly health and safety committee. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted. Fourteen accident/incident forms (four rest home, six hospital and four dementia care) were reviewed across June, July and August 2018. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for six incident forms reviewed for unwitnessed falls or any known head injury. Next of kin had been notified for all incidents/accidents as per written instructions for notification of accident/incidents. The caregivers interviewed could discuss the incident reporting process. The general manager interviewed could describe situations that would require reporting to relevant authorities. There have been three section 31 notifications reported since the last audit, in relation to a pressure injury (stage three) and a medication error, both were in January 2018 and a police investigation (missing resident) in July 2018.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. The register of nursing practising certificates and allied health professionals is current. Ten staff files were reviewed (one general manager, one care manager, one clinical coordinator, one-unit manager/lifestyle support manager, one RN and five caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation

		programme provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. Staff complete competencies relevant to their roles. Care staff are supported to complete a literacy programme and Careerforce aged care qualifications. The quality manager is the Careerforce assessor. Nursing staff are supported to attend external education. All eleven RNs have completed their interRAI training. The staff education/training plan includes monthly full study days that cover the two yearly mandatory training requirements. Other training provided on-site includes moving and handling (physiotherapist) and medication (pharmacist). All nursing staff, caregiver team leaders and activities personnel have current first aid certificates. All fourteen caregivers who work in the dementia care unit have completed the dementia unit standards.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager is on duty during the day from Monday to Friday. The general manager is on duty for any operational or facility concerns. There are two RNs on duty 24-hours a day, seven days a week. The care manager and care coordinator share the on-call requirement for clinical concerns. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the general manager and care manager who respond quickly to after-hours clinical or facility concerns. The prospective owner advised that rosters, staffing levels will transition to their staff policies and procedures from 1 October 2018. The facility is split up into three wings, the West wing, North/Rennie wing, and Duncan Lodge (dementia care) wing. In the West wing there are 32 rooms with capacity for 34 residents (two are double rooms catering for couples). There were 29 residents in total; eight hospital and 21 rest home residents. There is a care manager who is supported by one RN on the morning and afternoon shifts and one on

		the night shift. The RNs are supported by six caregivers on the morning shift, five on the afternoon shift, and two caregivers on the night shift. In the North/Rennie wing there are 34 rooms with capacity for 39 residents (five are double rooms catering for couples). There were 35 residents in total, 16 hospital and 19 rest home residents. There is a care coordinator who is supported by one RN on the morning and afternoon shifts and the one on the night shift. The RNs are supported by five caregivers on the morning shift, four caregivers on the afternoon shift, and two caregivers on the night shift. In the Duncan Lodge dementia care wing there is the potential for 25 rooms though one of the rooms has yet to be commissioned. There were 24 residents in total. There is a unit manager/lifestyle support manager who is supported by one EN on the morning shift. The RNs from the North/Rennie wing cover the afternoon and night shifts in the dementia wing. There are four caregivers on the morning and afternoon shifts, and two caregivers on the night shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Code of Consumer Rights,

		complaints information, advocacy, and admission agreement. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are evidenced in nine resident files sampled – there was a placement authority in the tenth and evidence of ongoing communication attempting to have the admission agreement signed. The admission agreement reviewed aligns with the ARRC contract and exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Twenty medication charts were reviewed (seven hospital, four dementia and nine rest home including one respite). There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of monthly robotic packs is completed by the night RN and any errors fed back to pharmacy. Registered nurses and enrolled nurses who administer medications have been assessed for competency on an annual basis. The service uses an electronic medication system. Education around safe medication administration has been provided. Medications were stored safely in all units (rest home, hospital and dementia care). Medication fridges (one is for storage of specimens only) are monitored weekly and evidenced to be within acceptable range. All eye drops and creams in medication trolleys were dated on opening. There are no standing orders in use. The main medication room with controlled drugs safe and medication fridge is in the north wing. There is evidence of weekly stocktakes of controlled drugs and six-monthly pharmacy audits.

		There were five self-medicating residents on the day of audit. All self-medicating residents had competencies checked and signed three monthly by the GP. The effectiveness of 'as required' medications is entered into the electronic medication system. Medication charts sampled were reviewed three monthly by the attending GP.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Meal services provided at Sprott House are contracted to a catering company. There is a head chef/site manager with support from three chefs and four kitchenhands (one casual) to cover the roster. The kitchen staff have completed food safety training. All food is prepared and cooked on the premises. There is a six-weekly winter and summer menu that has been reviewed by a dietitian. The menu includes resident choice. The chef receives dietary requirements forms for each new resident admission with documented nutritional needs, likes and dislikes. Vegetarian, gluten free and modified/soft/pureed meals are provided. Alternative meals are offered as required. Sandwiches and nutritious snacks are delivered to the dementia unit daily. The kitchen is notified of any dietary changes, special requirements and any residents with weight loss. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Chemicals are stored safely. Residents and the family members interviewed were happy with the quality and variety of foods. The kitchen had recently undergone extensive refurbishment including the installation of new benches, shelving, flooring and painting.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to potential residents is recorded and communicated to the potential resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RNs complete an initial assessment on admission including (but not limited to); a) continence, b) pressure area risk assessment, c) nutrition d) falls risk assessment, e) pain assessment, f) behaviour assessment and monitoring as appropriate. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes for long-term residents under the ARRC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. The long-term care plans reflect the outcome of the assessments. The GP completes a medical admission within five working days. All residents interviewed were satisfied with the support provided. Assessment process and the outcomes are communicated to staff and assessment tools link to individual care plans. Residents and families advised that they are informed and involved in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' long-term care plans reviewed were resident-focused and individualised. Hospital, rest home and dementia care plans reviewed, all documented the required supports/needs to reflect the resident's current health status. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. Examples sighted are cares required for wounds, infections and 'general issues' two cases being left sided weakness and insulin use. Ten resident files reviewed identified that family were involved. There was evidence of allied healthcare professionals involved in the care of the resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans are goal orientated and reviewed at six monthly intervals or when a resident's condition alters. The RN initiates a review and if required, GP or nurse specialist consultation. Care plans are updated to reflect intervention changes following review or change in health status

		as evidenced in all long-term resident files. Family notifications are documented on the contact with family member record page held within the resident file. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for 14 residents (seven rest home, one dementia and six hospital) and 21 wounds (three skin lesions, ten skin tears, four ulcers and four other). There is access to a wound nurse specialist and district nurses for advice for wound management. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. The RNs interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Wound specialist nurse services have been provided. Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours. All falls are reported on the resident accident/incident form and reported to the RN and care manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist is contracted and visits the site twice weekly for six hours per week.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	A lifestyle support manager who is a trained occupational therapist is employed full time to coordinate the activities programme for all residents. She is supported by two activities assistants who between them provide an activities programme seven days a week. There is a main activities programme provided in the west wing that all residents (as appropriate) are welcome to attend and a separate programme in the dementia unit. Activities provided are appropriate to the resident's physical and cognitive needs including those of the younger resident should there be any. Residents in the dementia unit have plans that include activities to manage behaviours over the 24-hour period and dementia staff provide activities when activities staff are not present. There is one-on-one time with residents evidenced in the individual

		monthly activity progress notes. Activities programmes are displayed throughout the facility. Community links include an adopt-a-grandparent scheme with a local school. Canine friends visit residents on a regular basis. Volunteers visit along with 'the exercise lady' twice a week and there are a regular number of entertainers each month. Church services are held twice weekly and individual visits are made to residents by church members. Mobility taxis are used for outings. The activity person makes contact with a resident and their family/whānau and an activity care plan is developed within three weeks of admission in consultation with the resident/family/whānau and reviewed six-monthly with the long-term care plan. Attendance sheets and individual monthly progress notes are maintained. Feedback on the programme is received through two monthly resident meetings, 1:1 with family and residents and an annual satisfaction survey. Residents and relatives interviewed overall reported that they enjoyed the activities on offer.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In files sampled, all initial care plans were evaluated by the RNs within three weeks of admission. The long-term care plans reviewed were evaluated at least six monthly or earlier if there was a change in health status in nine of ten files sampled (one was a respite). There is at least a three-monthly review by the GP. Overall changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services after updating the GP first. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. Referral forms and

		documentation are maintained on resident files.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies in place for waste management, waste disposal of general waste and medical waste management. There are approved sharps containers in use for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals in use are stored securely on the cleaner's trolley. Laundry and sluice rooms are locked when not in use. Material safety datasheets are available in all key areas. The hazard register identifies hazardous substances. Gloves, aprons, and goggles are available in key areas for staff. Staff receive education on chemical safety. Interviews with staff described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Sprott House provides rest home, hospital and dementia care in wings within the same facility. The service displays a current building warrant of fitness which expires on 18 July 2019. There are several communal areas provided for both groups and individuals including a number of smaller dining areas with kitchenette. There are sufficient communal toilets adjacent to the lounge and dining areas. Many of the resident rooms also have ensuites. There is secure access to the dementia unit with various quiet spaces for residents and families to enjoy time together including a secure sensory garden/courtyard. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens with a new easy access outdoor area currently nearing completion. Hot water temperature checks are conducted and recorded monthly by the maintenance person. Hot water temperatures are recorded in rotating locations throughout the facility monthly; where temperature was above the 45 degrees, corrective actions have been initiated. The service utilises hoists for resident transfer, these are calibrated and have electrical checks annually (last done August 2018). Interviews with caregivers and RNs confirmed there is sufficient medical equipment to

		meet resident needs, including pressure relieving mattresses, shower chairs, wheelchairs, walking frames, hoists, heel protectors, transferring aids, chair scales, blood pressure machine and thermometers. The prospective owner advised there are no plans at this stage to make changes to the environment except continuing with ongoing maintenance.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	The service has a combination of single rooms with shared bathroom facilities (North wing) and several rooms throughout the facility with their own full ensuites (Duncan Lodge, Rennie wing and West wing). The Rennie wing has larger rooms that can accommodate couples. There are two double rooms that had married couples sharing at the time of audit. The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and hygienic state. Regular audits of the environment are completed as per the quality programme. Residents interviewed stated their privacy and dignity are maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs and are sufficient to meet the needs of the resident.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The rooms are quite spacious and meet the assessed resident needs. Residents can easily manoeuvre mobility aids around the bed and personal spaces. The bedrooms are personalised. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place and staff were seen to use hoists. Residents interviewed are very happy with their rooms.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are lounge and dining rooms in each unit and a conservatory in the dementia unit along with a large communal activities room. The dining areas are spacious and are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed reported they can move around the facility.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Sprott House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the laundry staff. Staff attend infection control education and there is appropriate protective clothing such as aprons and gloves available. There are dedicated laundry and cleaning staff. Manufacturer's data safety sheets are available. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning audits are conducted. Internal audits and resident satisfaction surveys identify any areas for improvement.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The staffing level provided adequate numbers of staff to facilitate safe care to rest home, dementia and hospital level residents.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment is warm and comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall	FA	The role of the infection prevention and control (IPC) coordinator was taken up by the care manager (RN) in December 2017. The new IPC coordinator has attended the DHB IC meetings and is commencing the MOH IC online education. The IPC team also includes the manager, an

be appropriate to the size and scope of the service.		RN, a caregiver, staff from support services, housekeeping and food services. The team meets three monthly and copies of the minutes are made available to staff in the staff rooms. The IPC coordinator can access external specialist advice from GPs, laboratories and DHB IPC specialists when required. The IPC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and management team and external expertise when required. Infection control is a standing agenda item at the monthly staff meetings and quality meetings. Staff are informed about IPC practises and reporting. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IPC coordinator and entered in the infection register. There is a job description for the IPC coordinator including the role and responsibilities of the position. Infection control is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The care manager is the IPC coordinator. Infection control matters are taken to all staff and quality meetings (minutes reviewed). The IPC coordinator can access external DHB, IPC nurse specialist, laboratories, and GPs specialist advice when required. She has the main responsibility for reviewing the IPC programme annually. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GPs is available for additional training support. The IPC coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are	FA	Sprott House has infection control policies and an infection control manual, which reflect current practise. The IPC programme defines roles and responsibilities of the IPC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IPC coordinator. The

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		IPC programme is reviewed annually by the IPC coordinator and the quality committee who can access external specialist advice to do this. Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IPC coordinator is the care manager who attends DHB IPC training and update sessions every three months. All new staff receives infection control education at orientation, including hand washing and preventative measures. Annual infection control education occurs. The training folder records the staff education and attendance. External resources including DHB, laboratories and GPs ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the flu vaccine. There have been no outbreaks since the previous audit, however, there is an understanding of outbreak management evidenced in RN and caregiver interviews.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The care manager uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality oversight committee meetings, the health and safety meetings and to the board. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Results of infection control data collated, is graphed and discussed at all staff meetings. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of

		the facility. Infection control data is benchmarked monthly with health care help.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Sprott House has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. Forms include a restraint and enabler register, a restraint assessment form, a restraint and an enabler consent form and a restraint and enabler monitoring form. At the time of the audit there were thirteen residents with restraints (all bed rails) and one resident using an enabler (bed rail). Staff have received training on restraint minimisation. The prospective owner/organisation has policies and procedures around restraint minimisation.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint coordinator is the unit manager/lifestyle support manager who is a registered occupational therapist and has been in the role for over six years. There is a restraint coordinator job description. Restraint and consent is in consultation/partnership with the resident (as appropriate) or family member, the restraint coordinator, GP and an RN. There is provision for emergency restraint following consent from family. Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments are undertaken by the restraint coordinator or RN in partnership with the resident and their family and the resident's GP. Restraint assessments are based on information in the initial care assessment, long-term care plan, resident/family discussions, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form, and this is completed in consultation and discussion with the resident/family and GP. Three of three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three-monthly evaluations.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint use is reviewed three monthly in the facility restraint meeting and also as part of monthly restraint register reviews. Care plans reviewed of three of three residents with restraint identified observations and monitoring.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Written evaluations are completed by the restraint coordinator at least three monthly or earlier if required. Families are included in restraint review as part of the long-term care plan review. Effective de-escalation strategies are reviewed by the restraint coordinator and restraint committee. Individual restraint use is monitored and recorded by care staff. The policy clearly states the timeframes for monitoring, with a minimum of two hourly checks overnight when bedrails are in situ. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least three monthly as part of the medical review and six monthly as part of the long-term care plan review in consultation with the resident/family/whānau as appropriate. Restraint usage is monitored regularly by the restraint coordinator. Incident/accidents are reviewed by the restraint coordinator. Corrective actions are monitored. There is a monthly restraint coordinator report (including the hours of restraint). Restraint is discussed at all clinical and management meetings.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.