

Mateus Enterprises Limited - Seaview Home

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 HealthShare 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: Mateus Enterprises Limited

Premises audited: Seaview Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 6 August 2018 End date: 7 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: 28

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Mateus Enterprises Ltd, trading as Seaview Home, provides rest home level care for up to 28 residents. Short stay /respite and day programme attendance can also be provided subject to bed availability. Day to day operations and governance is provided by two directors, one of whom is the designated clinical manager (CM) and the other oversees the building, grounds, equipment and procurement.

There have been no significant changes to the service since the previous surveillance audit in 2017.

This re-certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Nelson Marlborough district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the directors, staff, a visiting district nurse and a general practitioner (GP). The GP, visiting nurse, residents and families spoke positively about the care provided.

This audit identified three areas requiring improvement. These are related to storage of food items, the building warrant of fitness and the security of the building.

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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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and family/whanau on admission. Their privacy, independence and personal safety is protected. Care and support is provided in a manner which recognises the residents' culture, values and beliefs. Residents who identify as Maori will have their needs met in a manner that respects their cultural values and beliefs. Care will be guided by a Maori health care plan and other related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles.

Communication is open and resident choices are recorded and acted upon. Adequately documented processes are in place for informed consent. Residents and family/whanau are assisted and encouraged to formulate advanced directives. Advocacy information is available for residents and family/whanau. Links with family/whanau and the community are encouraged and supported by the service provider. 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. | | Standards applicable to this service fully attained. |
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An annual strategic plan describes the scope, direction, goals, values and mission statement of the organisation. The directors and a small senior management team are monitoring all aspects of the services provided. The director/clinical manager has been the role since 1996 and is an experienced registered nurse who is suitably qualified to manage an aged care service.

The quality and risk management system collects quality 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. Policies were current and are reviewed and updated as needed at regular intervals.

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

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

Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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The registered nurse (RN) and clinical manager (CM) are responsible for the development of care plans in consultation with staff and family members' representatives. Care plans and assessments are developed and evaluated within the required time frames. Short term care plans are developed for any acute needs as required.

Planned activities are appropriate for the residents' assessed needs and abilities. Residents and Family/whanau interviewed expressed satisfaction with the activities provided by the activity coordinators.

The medication management system meets the required legislation and guidelines. Medication is administered by staff with current medication competencies. The organisation uses an electronic system in prescribing, dispensing and administration of medications.

Three monthly reviews are completed by the attending general practitioners (GPs.). Residents are provided with nutritious meals that cater to their preferences and dietary requirements.

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. | | Some standards applicable to this service partially attained and of low risk. |
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The facility meets the needs of residents and was clean and well maintained. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and safe for residents' use.

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

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

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Seaview Home has a philosophy and practice of no restraint. There were no restraints in use. On the days of audit there were three enablers (bed levers) in use to assist residents to sit up in bed. These were consented to by the residents using them. .Policies and procedures meet the requirements if a restraint is required and staff education is ongoing.

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 control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator (ICC) is responsible for co-ordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff and quality 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) |
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| Standards | 0 | 42 | 0 | 3 | 0 | 0 | 0 |
| Criteria | 0 | 90 | 0 | 3 | 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) |
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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>Interviewed staff demonstrated knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the staff training education programmes. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents. The residents and family/whānau reported that staff respects their rights as part of their everyday practice.</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>Policies and procedures on consent support the residents' right to make informed decisions. The CM and RN reported that informed consent is discussed and recorded at the time the resident is admitted to the facility. The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives. The residents' files sampled had the required consent forms signed by the resident, or where appropriate, signed by the enduring power of attorney (EPOA). The files contained copies of any advance care planning and the residents' wishes for end of life care. Staff acknowledged the residents' right to make choices based on information presented to them. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained.</p> |

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| <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> | <p>FA</p> | <p>There were appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy / support is provided annually and staff demonstrated understanding of how residents can access advocacy/support persons.</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> | <p>FA</p> | <p>There are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</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> | <p>FA</p> | <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 said they felt comfortable and wouldn't hesitate to raise a concern if they had one.</p> <p>The complaints register reviewed recorded a total of two complaints received since 2015 including one in 2017. This has been acknowledged in writing, and investigated within the timeframes stated in policy. Follow up correspondence was not responded to by the complainant and the matter is now closed.</p> <p>The director/nurse 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 complaints to the Health and Disability Commissioner (HDC) nor any requests for advocacy services to provide support in this certification period.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>The Code and information about the Code, advocacy services and the complaints process are provided on admission and displayed at the facility. The CM reported that an advocate visits the service on a regular basis.</p> <p>Residents and family/whanau interviewed were aware of their rights and confirmed that information was provided to them during the admission process. Seaview home information pack was sighted and outlines the services offered. Signed residents' agreements were sighted and meet the requirements</p> |

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| | | of this standard and district health board requirements. |
| <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>The privacy and dignity policy explains how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting resident's individual needs, cultural, religious beliefs and values. Rooms are single and double occupancy and maintain physical, visual and auditory privacy. Personal property is maintained in a secure manner. Policies and procedures on abuse and neglect include definitions and reporting requirements.</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 individual and cultural, values and beliefs.</p> | FA | <p>The Maori perspective on health is documented and includes Maori models of Health and barriers to access. Terminal care and death of the Maori resident is included. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. The organisation maintains contact with a local Maori provider for advice and support if required. Cultural safety training is provided to all staff. The Code is available in Maori and satisfaction surveys include cultural and spiritual beliefs.</p> |
| <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 | <p>Cultural needs are determined on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident. Residents' values and beliefs are discussed and incorporated into the care plan. Residents and family/whanau members interviewed confirmed they are encouraged to be involved in the development of the long-term care plan. In interviews conducted, staff demonstrated an understanding of cultural safety in relation to care.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>Policies sighted define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct and professional behaviour is included in the employment and orientation process.</p> <p>Interviews with residents and family/whanau, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. In interview, the GP confirmed the provision of</p> |

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| | | <p>consistent and respectful care to all residents.</p> <p>The CM and RN in interviews conducted, demonstrated awareness of the importance of maintaining boundaries and processes they are required to adhere to.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>There are systems in place to ensure staff receive a range of opportunities which promote good practice within the facility. Staff reported that they were satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice. There are regular visits by the GPs and allied health providers as required. The CM and RN are available and accessible to care staff for clinical support.</p> |
| <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>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their family/whanau. Documenting of open disclosure following incidents/accidents was evident. The service has access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Families reported they are informed of any events or concerns.</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 plan which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of directors/management meeting minutes for 2017-2018 confirmed regular discussions and actions to monitor performance for example, occupancy, human resources (HR), service performance, and any emerging risks and issues. Interview with both director/operators and documents reviewed verified effective methods for ensuring services are provided in ways to meet the needs of residents.</p> <p>The director/clinical manager is a registered nurse (RN) with a current practicing certificate and has been in the role for 22years. This person demonstrated knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development in nursing and at least eight hours of education per annum as required in the agreement with the DHB.</p> <p>The service holds contracts with Nelson Marlborough DHB, for rest home level care and respite. There is also a contract for one person who is under the age of 65 years. This resident's records were included in the audit sample. There were no people in the facility for respite care on the days of audit. The facility has a maximum capacity of 28 beds. On the days of audit all beds were occupied.</p> |

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| <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> | <p>FA</p> | <p>The full time RN carries out all the required duties under delegated authority when the director/nurse manager is absent. Another RN who is experienced in the sector, is also employed on a casual basis and available when needed for planned absences. Staff reported this arrangement is seldom needed but works 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> | <p>FA</p> | <p>Seaview Home has established quality and risk management systems for determining compliance and where improvement is needed. Service delivery monitoring includes collation and analysis of incidents/accidents, complaints and infections, and the outcomes of internal audits. Resident and family satisfaction surveys are completed annually. The most recent family survey produced a high (98.6%) rate of return with overall high satisfaction. Two comments seeking minor changes had been responded to.</p> <p>Minutes from the directors/management meetings and monthly staff meetings reviewed, confirmed that service delivery information is reported and discussed. Staff reported their involvement in quality and risk management activities through adapting their practices and via internal audit activities.</p> <p>Where service shortfalls are identified (from feedback or internal audits) relevant corrective actions are decided and implemented. Corrective or preventative actions were also noted on incident forms. Evidence that these matters are clearly communicated back to staff was confirmed by staff interview who said they receive memos or verbally at handover or general meetings.</p> <p>The 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 directors described their processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both are familiar with the Health and Safety at Work Act (2015) and its requirements. A senior carer interviewed, is the nominated health and safety officer and has achieved stage one education relative to the role. This person manages the hazard register, conducts environmental inspections, provides education and mentoring about safe lifting/manual handling and inducts all new staff to the health and safety systems in place. There have been no staff</p> |

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| | | injuries since the previous surveillance audit. |
| <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> | FA | <p>Staff document adverse and near miss events on accident/incident forms. A sample of forms from 2017-2018 were consistent in clearly describing and detailing the incident and recording who had been notified. Each falls event had attached records of post fall neurological observations. The director/clinical manager reviews all incidents, investigates where necessary and documents preventative actions which are followed-up. The director/ clinical manager demonstrated understanding about essential notification reporting requirements, including for pressure injuries. This person advised there have been no events requiring notification to the Ministry of Health, or the DHB since the previous audit.</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>Staff 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. Copies of practising certificates for the registered health practitioners providing services at Seaview Home are on file. A sample of staff records reviewed, confirmed the organisation's policies are being consistently implemented and records are maintained. The office administrator routinely reviews personnel records to ensure compliance with policy and employment legislation.</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 showed documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis and occurs each month. These include mandatory training requirements such as fire drills, first aid and medicines competency for those who administer medicines and other education to meet the requirements of the provider's agreement with the DHB. A majority of carers have educational achievements related to care of older people. The staff records reviewed demonstrated attendance at ongoing training and completion of annual performance appraisals.</p> <p>There are two registered nurses who are trained and are maintaining their annual competency requirements to undertake interRAI assessments.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> |

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| <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | | <p>Observations and review of a two-week roster cycle confirmed more than adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff have a current first aid certificate. The directors and care staff interviewed stated that staffing levels are adjusted to meet the changing needs of residents. There is an afterhours on call roster shared by the two RNs, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. The residents and family interviewed supported this.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>Residents' information is entered into the files on admission by the CM or RN. A register is kept for current and past records. Resident information is stored securely in the nurses' station. Review of resident records indicated they include reports from all health professionals. Daily progress notes are maintained, and records are integrated. Entries are legible, dated, signed and designated. Archived records are stored for 10 years in a secure and safe manner, these are retrievable as required.</p> |
| <p>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.</p> | <p>FA</p> | <p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Seaview Home's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives interviewed confirmed that they received sufficient information regarding the services to be provided.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB and InterRAI transfer form are utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p> |
| <p>Standard 1.3.12: Medicine Management</p> | <p>FA</p> | <p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. The organisation uses the electronic system for e-prescribing, ordering, dispensing and administration. The e-prescribing electronic system is accessed by use of individual</p> |

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| <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>passwords and generic facility log in. Medication entries complied with legislation, protocols and guidelines.</p> <p>Medications are stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the CM or RN when the resident is transferred back to service. All medications are reviewed every three months and as required by the GPs. Allergies are clearly indicated, and photos uploaded for easy identification.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RN was observed administering medicines following the required medication protocol guidelines and requirements.</p> <p>The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medications are stored appropriately.</p> <p>There was one resident self-administering medication at the time of the audit and assessed as competent. Medications are stored in a lockable container not accessible to other residents. Records of administration are maintained. A self-administration medication policy is in place.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>PA Low</p> | <p>The food service is provided on site by one cook with input from a small kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in April this year. Any recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, however there is a finding related to storage. The service has submitted their food control plan to the local council on 14 June 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Kitchen staff have obtained safe food handling qualifications.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion. There is no one on site who requires assistance with eating.</p> |

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| <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 | <p>The RN reported that all consumers who are declined entry are recorded on the pre-enquiry form. When a resident is declined entry, relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and family/whanau expressed satisfaction with 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>Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals are specific, realistic, measurable and clearly documented. Interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>The documented interventions in short term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were sighted and the staff confirmed they have access to the supplies and products they needed,</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements</p> | FA | <p>The planned activities are meaningful to the residents. The activity coordinator develops the programme in consultation with the CM who helps with activities at times. The service is in the process of recruiting an extra part time activity coordinator to co-share the workload. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents and including those under 65. Activities resource materials are accessible for staff to utilise. The activities coordinator</p> |

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| <p>are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>reported that they modify activities based on the resident's response, interests, capability and cognitive abilities of the residents.</p> <p>The residents were observed to be participating in meaningful activities on the audit days and going offsite with family/friends. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Residents' survey on the activities programme is conducted twice a year and any feedback from residents and family/whanau is acted upon promptly.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident's long-term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff are consulted during care plan review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p> |
| <p>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.</p> | FA | <p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GPs.</p> |
| <p>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.</p> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals/cleaning products and provide training for staff on new chemicals. All staff who handle chemicals have attended chemical training. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |

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| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>PA Low</p> | <p>The building warrant of fitness expired on 01 July 2018. There is a requirement in 1.4.2.1 related to this.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Tasks scheduled in the building maintenance programme are carried out at regular intervals. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the director, the health and safety officer and on-site visual inspections. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident group and setting.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. They said requests are appropriately actioned and that they are happy with the environment.</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> | <p>FA</p> | <p>There is an adequate number of accessible bathroom and toilet amenities which are located in each wing of the facility, and are in close proximity to residents' bedrooms. All bedrooms have a washbasin with hot and cold running water. Hot water temperature is regulated by tempering valves and monitoring of the temperatures at the tap is carried out monthly. The temperature records sighted show hot water is delivered within a safe range of temperatures. Residents interviewed were very happy with the provision, cleanliness of and access to ablution areas. 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> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. One bedroom is shared by a couple, all others are single occupation. Rooms are personalised with furnishings, photos and other personal items displayed. Each room is unique in its size and shape and can easily accommodate a bed, seating and other furniture. There are additional rooms and spaces for storage of mobility aids, wheel chairs and mobility scooters. Family and residents expressed satisfaction with their bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> | <p>FA</p> | <p>This is a small rest home with a spacious and welcoming communal lounge and a separate dining room for residents situated centrally and within easy walking distance from residents' rooms. The lounge is used for activities and has varied seating configurations if someone doesn't want to</p> |

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| <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | | <p>participate in the programme. There is a small library and telephone space. All residents can easily access their rooms for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |
| <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> | <p>FA</p> | <p>Care staff on each shift provide the laundry services. Staff interviewed about laundry demonstrated good knowledge of laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and that their clothes are returned in a timely manner. A new industrial washing machine and dryer have recently been installed. One cleaner is employed for four and a half hours per day, five days a week. This person changes each resident's bed linen once a week and stated there is sufficient time allocated for completing daily/weekly tasks. The care staff carry out cleaning tasks such as rubbish removal, light dusting and bathroom cleaning on the weekend. All staff have attended training in the safe handling of the chemicals on site and in health and safety matters, as confirmed by review of personnel files and interviews with staff including the cleaner. Bulk chemicals are stored in a lockable room when not in use and are decanted into clearly labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. All areas of the facility were spotless on audit days. The residents and family members interviewed were happy with the cleanliness of their rooms and other areas in the home.</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> | <p>PA Low</p> | <p>Policies and guidelines for emergency planning, preparation and response are current and are 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.</p> <p>A fire evacuation plan has been approved by the New Zealand Fire Service. Trial evacuations take place every six months and a copy of the finding from each drill is sent to the local fire service. The most recent drills occurred on 11 April 2018 and 11 September 2017. The time taken for evacuation is recorded and there have been no issues or risks identified. The most vulnerable or mobility impaired residents are listed on the fire board and are assisted first. The new staff 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 28 residents. Water storage tanks are located around the complex, and emergency lighting is regularly tested.</p> <p>The call bell system was functional on audit days and staff were observed to attend to these in a timely manner. Residents and families were happy with staff responses to call bells at all times of the</p> |

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| | | <p>day and night.</p> <p>Staff lock the external doors and windows each night for security purposes. New aluminium windows had just been installed throughout the facility prior to the audit. These did not have security stays installed. There is a requirement in criterion 1.4.7.6 to ensure the windows that are most easily accessible are secured.</p> |
| <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 electric 'night stores' in communal areas and individually temperature-controlled panel heaters in residents' rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the home is maintained at a comfortable temperature year-round.</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>Seaview Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The CM is the infection control coordinator (ICC) and has access to external specialist advice from the GP practice and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme has been reviewed in the last 12 months. Rates of infections are discussed at monthly staff and quality meetings. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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</p> | FA | <p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p> |

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| programme and meet the needs of the organisation. | | |
| <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 | The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures such as washing of hands, wearing of gloves and gowns where appropriate. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. |
| <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 | Staff education on infection prevention and control is conducted by ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training content meets best practice and guidelines. The ICC had completed an online infection control training to keep their knowledge current. External contact resources included: GP practice, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| <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 | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use</p> | FA | Interview with the clinical manager/restraint coordinator provides evidence that Seaview Homes restraint philosophy and practice is to maintain a restraint free environment. There have never been any restraints used. There were three enablers (bed levers) in use on audit days. Resident files reviewed confirmed these were voluntary and had been consented and agreed to by the residents |

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| <p>of restraint is actively minimised.</p> | | <p>using them.</p> <p>The restraint policy describes processes for assessment, consent and monitoring that would meet this standard in the event that a restraint intervention was required. It contains definitions that are congruent with this standard and describes methods for avoiding or minimising the use of restraint. Policy designates a restraint coordinator, and clearly describes the processes for evaluation, review and ongoing staff education.</p> <p>Review of a sample of staff files and training documents confirmed that staff engage in ongoing education. This included managing challenging behaviour, use of de-escalation techniques and preventing the use of restraint. There is also an emergency restraint policy which authorises an RN to initiate an emergency restraint before a GP assessment.</p> |
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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 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p> | PA Low | <p>Pantry inspection and interviews revealed there is no system for recording when bulk dry food stock is decanted. All other stored food is dated.</p> <p>Bags of potatoes were being stored too close to the ground outside. This was rectified during the audit.</p> | Storage of some food items do not meet safe storage guidelines. | <p>Ensure all food items are stored safely and dated when taken out of the original packaging or decanted</p> <p>60 days</p> |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Low | <p>The building warrant of fitness (BWOFF) expired on 01 July 2018. Interview with the director who oversees property matters revealed that the process for renewing the BWOFF began in January 2018. A delay has occurred due to a difference of opinion between external contractors about building requirements. It is anticipated this will be resolved and that the district council will issue a new warrant.</p> | The building of warrant of fitness has expired. | <p>Provide evidence of current BWOFF</p> <p>30 days</p> |

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| <p>Criterion 1.4.7.6</p> <p>The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.</p> | PA Low | <p>Staff check that external doors and windows are closed at sunset for security purposes. There are no security stays on any of the external windows. The office window and the resident bedroom windows that face the front door carpark/driveway are vulnerable for unauthorised entry. There are also a few windows that could be accessed from the front terrace.</p> | <p>The newly installed aluminium windows surrounding the building do not have any security latches.</p> | <p>Ensure that security latches are installed on the windows that are the easiest to gain outside entry.</p> <p>90 days</p> |

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.