# Fergusson Home Limited - Fergusson Home and Retirement Village

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Fergusson Home Limited

**Premises audited:** Fergusson Home and Retirement Village

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 16 October 2018 End date: 16 October 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:** 37

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Fergusson Home and Retirement Village provides rest home level care for up to 44 residents. The service is privately owned and operated and is one of two facilities owned by the same provider. It is managed by a nurse manager who holds a current nursing practising certificate. She is supported by two registered nurses and a management team based at the organisation’s head office. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, managers (which included two support managers from head office), staff, and a general practitioner.

This audit identified no areas requiring improvement. Improvements have been made to Maori health care planning, data evaluation, resident information, care planning, activities and hot water temperatures, addressing all areas requiring improvement at the previous audit.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

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

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

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

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

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

Residents’ information is accurately recorded with the support of up to date templates.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision of care, transfer and review are provided within time frames that safely meet the needs of the residents and contractual requirements.

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

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident’s needs, a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite village kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a five-week rotating menu which has been approved by a registered dietitian. Residents’ nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## Safe and appropriate environment

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

There is a current building warrant of fitness. The hot water temperatures have been maintained at or below the identified safe temperature for aged care facilities.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of audit. Policy contains a comprehensive assessment, approval and monitoring process should restraint be required. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## 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 | 20 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 43 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints forms are clearly displayed for ease of resident and visitor use.  The complaints register reviewed showed that one complaint had been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The internal complaints audit completed in June 2018 confirmed the service gained a 100% compliance with policy when dealing with complaints management. The 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 received from external sources since the previous audit. |
| 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 | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The registered nurse interviewed reported that there is one resident who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model with a further emphasis on partnership, participation and protection and traditional Maori healing which is evidenced and integrated into long-term care plans with input from cultural advisers within the local community, as required. The cultural awareness policy provides a list of all Maori Health service providers in the local community and guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. At the time of audit, the resident and whānau were not available for interview. The previous audit identified an area for improvement to ensure that all residents that identify with their Maori culture have information provided in their care plans to support their individual values and beliefs. The corrective action is now addressed, and records were available to demonstrate this. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There are four residents with a significant sensory impairment and appropriate equipment and resources were sighted and highlighted in residents’ long-term care plans reviewed, for example, a communication whiteboard, large call bell, signs to alert staff on the resident’s door and the importance of a decluttered environment. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The quality and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the senior management group, which includes the owner, showed adequate information to monitor performance is reported. Items reported including health and safety, infection control, internal audits, medication errors, incident and accidents, admission enquiries, bed status, wounds, staffing hours, emerging risks and issues. The senior management group consists of the owner, business manager, operations and human resources manager, administration manager, purchasing and maintenance manager, management support person (who oversees quality data) and the two nurse managers from both facilities owned by the same company. The senior management group meets quarterly and the forum is used to discuss any issues that arise and to review the progress of any quality actions that have been put in place.  The service is managed by a nurse manager who holds relevant qualifications and has been in the role for over eight years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at in-service training and education, at quarterly Lakes District Health Board (LDHB) age care meetings, and age-related conferences.  The service holds contracts with LDHB for respite care and rest home level care. At the time of audit one resident was receiving services under the Short-Term Residential Care Respite contract and 36 residents were receiving services under the Age-Related Residential Care Contract. This included one resident under the age of 65 years. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents - covering falls, infections, wounds and pressure injuries. Evaluation of quality data is documented to show the outcome of quality improvements undertaken. Examples sighted related to completion of the food safety plan, the introduction of an electronic medication system, and environmental updates. This was an area identified for improvement in the previous audit and has been fully addressed by the service.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the weekly clinical management team meeting, the monthly staff meeting and quarterly senior management meeting. All quality data outcomes are posted on the staff notice board. Information is trended against previously collected data and benchmarked against the other facility owned by the same company. Staff reported their involvement in quality and risk management activities through audit activities, and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (February 2018) showed that all issues raised were fully addressed and the outcomes were discussed at the residents’ meetings and at staff meetings. All the negative comments were received from one survey response. Examples related to outing destinations, food variety and cleanliness of the facility. A full analysis of the survey results is documented. Residents were asked where they would like to go on their outings, this occurs at each residents’ meeting and no suggestions have been received. Residents were informed that the menu in place, which is approved by a registered dietitian, is followed and that they must inform staff if they have any specific likes or dislikes so the kitchen can cater for this. Cleanliness of the facility is monitored via observation and regular audits which have not identified any issues. No negative comments were made to the auditors during resident and family interviews on the day of audit.  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 are constantly monitored by the senior management group to maintain currency. All policies and procedures are personalised for Fergusson Home. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The nurse manager and management support person described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There is an up to date hazard register in place which clearly describes the hazard, the risk level, mitigating actions and who is responsible for the control of the hazard. This was reviewed as part of the health and safety audit undertaken in July 2018. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the senior management group and at staff meetings. Corrective actions are implemented as required. For example, when data showed an increase of falls in June 2018 (23) the increase was mainly attributed to one resident who was a ‘frequent faller’. Corrective actions implemented included bedside rails, the use of a baby monitor which alerted staff to any movement in the resident’s bedroom, the use of a floor bell call mat, moving the resident closer to the nurses’ station and frequent staff checks. The resident was reassessed and moved to a higher level of care. The outcome of this resulted in the July falls rate returning to within the average monthly rate (11) for the facility.  The nurse manager described essential notification reporting requirements, including for pressure injuries. However, it was noted that there was a resident admitted from the public hospital in May 2017 with a stage three pressure injury which was not notified to the Ministry of Health. When this was discussed on the day of audit staff confirmed they were not aware that notification was required if it was not acquired at the facility. The nurse manager was not informed the pressure injury was rated a stage three. The pressure injury has since healed. The nurse manager confirmed that this will be discussed at the next staff meeting to ensure all staff understand the reporting requirements related to pressure injuries. Management advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner’s inquests, issues based audits and any other notifications of infection outbreaks. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a six-week period and then annually. All files reviewed had a current performance appraisal.  Continuing education is planned annually by a dedicated nurse educator who works across both facilities owned by the same company. Education includes mandatory training requirements and is conducted six times a year, for eight hours. All staff are required to attend one of the annual education days which are conducted at Fergusson Home’s sister facility. This is monitored by the nurse manager and all staff files reviewed showed that each staff member had attended one of the four training days in the past year. If specific education is required, it is planned and undertaken at each facility. For example, Fergusson Home clinical staff have had education related to percutaneous endoscopic gastrostomy (PEG) feeding and cares. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The dedicated nurse educator is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI. |
| 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 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). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, 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. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of four-weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.  The nurse manager works eight hours per day, Monday to Friday, with seven days a week registered nurse cover for morning shift. There are dedicated cleaning and kitchen staff seven days a week. Laundry is undertaken as part of the care assistance duties. On call duties are shared between the nurse manager and two other registered nurses and this is advertised on the staff notice board and the on-call person is listed on the shift handover sheet. Members of the senior management team are also available should they be required. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.  The previous audit identified an area for improvement to ensure that all procedure templates, for example water temperature recording and incident and accident data forms used are current and all information pertaining to wounds is provided on required wound management plans in its entirety.  The corrective action has now been addressed and records were available to demonstrate this. |
| 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 | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.  At the time of audit, no residents were self-administering medications. The registered nurse interviewed was aware of the appropriate processes that need to be in place to ensure this is managed in a safe manner.  There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by one of two cooks 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 within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries and expires 16 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Though residents are given the option to have meals in their rooms, the cook interviewed stated that staff encourage residents to eat in the main dining room to reduce and minimise the risk of social isolation and encourage independence with nutritional input.  Evidence of resident satisfaction with meals was verified by resident and family interviews, documentation in the meal satisfaction book available to residents in the main dining room and residents’ meetings minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The previous audit identified an area requiring improvement to ensure that information to support the resident was consistent in the residents’ files documentation. The corrective action has been addressed. Records were available to demonstrate that the needs identified by the interRAI assessments, residents and their whānau were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The facility is supported by a house GP with eight residents choosing to continue with their own GP. A GP interviewed that supports residents at the facility verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by an activities co-ordinator who is currently away on extended leave and was not available at the time of audit. In the interim, the residents are supported by a diversional therapist holding a national Certificate in Diversional Therapy Mondays from 9.00 am to 4.00 pm and an activity support person Tuesdays, Wednesdays and Thursdays from 9.00 am to 2.00 pm. The Diversional Therapist is also available for ongoing support as required.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The previous audit identified an area requiring improvement to ensure that activity plans reflected the resident’s individual needs and care plans were evaluated in their entirety. The corrective action has been addressed, and records were available to demonstrate this. The resident’s activity needs are evaluated three monthly and as part of the formal six-monthly care plan review. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents interviewed confirmed they find the programme very active and ‘fun’. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the multidisciplinary team meeting where family are invited to attend, six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds and residents returning to the facility following an acute hospital admission. When necessary, and for unresolved problems, long term care plans are added to and updated. The medication electronic advice shows evidence of evaluations of residents who have had prescribed pro re nata (PRN) medications for pain. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness expires on the 12 October 2019. At the time of audit, the warrant of fitness displayed showed 12 October 2018. Documentation identified that all processes had been completed and that the facility was waiting for the new warrant of fitness from the compliance company. This arrived the day after audit and was emailed to show that all processes were met. |
| 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 | Temperature recordings sighted identified that hot water has been maintained at a safe temperature since the previous audit. If the recording went outside of the safe range of 45 degrees Celsius immediate actions were taken and the temperature was rechecked. This was an area identified for improvement in the previous audit and has been fully addressed by the service. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings, at staff handovers and a copy of this information is also provided in the staff room noticeboard monthly. Trends are identified from the past year and this is reported by the registered nurse and reported to all staff. In April 2018, 33 residents consented to the flu vaccine.  The facility has had a total of 38 infections since April 2018 through to and including September 2018. Two residents have been identified with seven of those 38 infections due to co-morbidities. The two residents’ files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked internally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. There have been no outbreaks in the last 12 months. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (nurse manager) provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities.  On the day of audit, the facility was restraint free with no residents using any form of restraint or enablers. Policy identifies that enablers are the least restrictive and used voluntarily at the resident’s request.  The nurse manager confirmed that restraint is used as a last resort when all alternatives have been explored. Restraint has only been implemented once in eight years and this is well documented with all processes being followed to ensure all restraint minimisations standards were met. Bedside rails were put in place for the safety of a resident in March 2018 and ceased in July 2018.  Staff undertake restraint education at least annually as part of their training day, and during interview, they proved to be knowledgeable about all required safe processes related to restraint and enabler use. |

# 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.