

# Waiwetu Holdings Limited - Fitzgerald Life Care

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## Introduction

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

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

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

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

The specifics of this audit included:

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| <b>Legal entity:</b>  | Waiwetu Holdings Limited   |
| <b>Premises audited:</b>  | Fitzgerald Life Care   |
| <b>Services audited:</b>  | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care);<br>Dementia care |
| <b>Dates of audit:</b>  | Start date: 12 November 2018    End date: 13 November 2018   |
| <b>Proposed changes to current services (if any):</b>   |  |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 35   |

# Executive summary of the audit

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## 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.

## General overview of the audit

Fitzgerald Retirement Complex is part of Anglican Living Aged Care organisation responsible to the Anglican Care Trust Board. Fitzgerald Retirement Complex provides care for up to 87 residents across rest home, hospital and dementia service levels. On the day of audit there were 35 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owner. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, staff and management.

The current acting manager is a registered nurse who reports to the director of Anglican Living. The acting manager is supported by three full time unit coordinators (registered nurses), a quality coordinator, a human resource manager, a property manager,

registered and enrolled nurses, healthcare assistants and long-serving staff. Residents interviewed were complimentary of the service and care they receive at Fitzgerald Complex.

The prospective owner (non-clinical), reported the current policies and quality system and some staff will remain in place following the purchase. The prospective new owner currently manages and owns another aged care facility in Christchurch. A general manager will be employed to assist with planned refurbishments and accounts. The acting manager and unit coordinators will remain employed under the prospective new owner, who will take on a chief executive role and provide guidance and support as required. The expected settlement date is 21 January 2019. The DHB is aware of the pending change of ownership.

This provisional audit did not identify any areas for improvement.

## **Consumer rights**

Fitzgerald Retirement Complex provides care in a way that focuses on the individual resident. The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## **Organisational management**

Fitzgerald Retirement complex is implementing a quality and risk management system that supports the provision of clinical care. Policies and procedures are maintained by an external quality advisor who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints and internal audits surveys. The health and safety programme meets current legislative requirements. There are human resources policies including recruitment, job descriptions, selection and orientation. The service has an orientation programme that provides new staff with

relevant information for safe work practice. There is an annual education/training schedule. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## **Continuum of service delivery**

There is an admission package available that covers services provided and the levels of care including specific information on the dementia care unit. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident (as appropriate) and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The electronic medicine charts reviewed, meet prescribing requirements and were reviewed at least three monthly.

A diversional therapist oversees the lifestyle facilitators in each unit and coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site by a contracted service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks are available 24 hours.

## **Safe and appropriate environment**

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The separate buildings both hold a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with access to shared ensuites or communal facilities. Documented policies and procedures for the cleaning and external laundry services are implemented with appropriate monitoring systems in place. Documented systems are in place for essential, emergency and security services. There is a staff member trained in first aid at all times.

## **Restraint minimisation and safe practice**

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint and one resident with an enabler at the time of the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## **Infection prevention and control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 45                  | 0  | 0                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 93                  | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 0  | 0                            | 0                                      | 0                              | 0                                      |

# Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome  | Attainment Rating | Audit Evidence   |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA                | <p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. Staff interviewed (one acting manager, one property manager, one quality coordinator, three registered nurses (RN), four healthcare assistants, one kitchen manager, three housekeeping staff and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service.</p> <p>Interview with the prospective owner confirmed their understanding of the consumer rights and their obligations to ensure the Code of Health and Disability Services Consumers' Rights and the Nationwide Health and Disability Advocacy Service information is clearly displayed and easily accessible to anyone to whom the information is relevant.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>                                    | FA                | <p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in eight resident files reviewed (two rest home including one</p>  |

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| <p>are provided with the information they need to make informed choices and give informed consent.</p>   |           | <p>resident under long-term support chronic health condition finding, two hospital and two dementia care resident files). Specific consents were sighted such as influenza vaccines and consent for student nurses to participate in resident cares. Advance directives if known, were on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. The GP deemed if the resident was competent or not and a medically indicated decision was evident. Copies of EPOA were present and activated as required.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All residents' files sampled had a signed admission agreement on file.</p> |
| <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>Residents and families are provided with information about the Nationwide Health and Disability Advocacy Service. Advocacy pamphlets are displayed in the entrance to the rest home and hospital/dementia buildings. Healthcare assistants interviewed were aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy. A Chaplain visits the facility each week.</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>The service maintains key linkages with other community and external groups including churches and schools. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Discussion with staff, residents and relatives, determined that residents are supported and encouraged to</p>  |

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|  |    | remain involved in the community.  |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>   | FA | <p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager leads the investigation of any concerns/complaints in consultation with the support of the quality manager and RNs as required, for clinical concerns/complaints. Complaints forms are visible throughout the facility. A complaints procedure is provided to residents within the information pack at entry. A complaints register is maintained. There have been 11 complaints made since the last audit. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. Corrective actions were implemented and followed up. Residents and families interviewed are aware of the complaints process.</p>  |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>  | FA | <p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is available at reception in both the rest home and the hospital/dementia buildings. A manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the bi-monthly resident/family meetings. Six residents (three rest home and three hospital) and three relatives (two hospital and one rest home) interviewed, reported that the residents' rights are being upheld by the service and that they received sufficient information to be able to make informed choices on matters that affect them.</p> <p>The prospective new owner currently owns and manages another facility and is knowledgeable in the Health &amp; Disability Commissioner Code of Rights and applies the code of rights in practice in their current role.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p> | FA | <p>The residents' personal belongings are used to decorate their rooms. Four caregivers interviewed, reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit,</p>   |

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| independence.  |    | confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff have received training around abuse and neglect. There were two double bedrooms that each had privacy curtains installed. Spiritual needs are identified, and church services are held.  |
| <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 service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. The service has access to a cultural advisor from the local Iwi Health Authority. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. At the time of the audit there were three residents in the service who identified as Māori. Māori resident files reviewed confirmed that Māori cultural values and beliefs are being met and are addressed in the care plan.</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>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p> <p>The service has a Chaplain appointed to the facility who is contracted to visit weekly and provide support to residents.</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>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the caregivers confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities. Interviews with</p>  |

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|   |    | <p>healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the caregiver's role and responsibilities. Professional boundaries are reconfirmed through education/training sessions, staff meetings and performance management if there is infringement with the person concerned.</p> <p>Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with eight healthcare assistants could describe how they build a supportive relationship with each resident.</p>  |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>  | FA | <p>The team are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day, with the staff demonstrating an inclusive and caring attitude to the residents. Residents and families interviewed stated they are very happy with the level of care provided. The service has implemented policies and procedures that are developed and reviewed by an external healthcare consultant. The policies and procedures meet legislative requirements. Healthcare assistants interviewed stated there are care guidelines in place to guide the delivery of care to residents. They receive a verbal handover from the RN and there is a daily handover sheet for every shift that details any significant events.</p> <p>The prospective owner stated that they will continue with best practice at Fitzgerald retirement complex.</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>There is a policy to guide staff on the process around open disclosure. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry, and any items they have to pay for that is not covered by the agreement. A specific introduction to the dementia unit booklet provides information for family, friends and visitors to the facility. The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required. Residents and family interviewed, confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Fifteen incident forms reviewed for October and November</p>  |

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|   |           | <p>identified family were notified following a resident incident. Discussions with healthcare assistants identified their knowledge around open disclosure. Family members interviewed confirmed they are notified of any incidents/accidents. There are resident meetings held bi-monthly with the opportunity for feedback on the services.</p>   |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>Fitzgerald Retirement Complex is part of Anglican Living Aged Care organisation responsible to the Anglican Care Trust Board. The manager provides a documented report monthly, to the Anglican Living Committee. Fitzgerald Retirement Complex provides care for up to 87 residents across rest home, hospital and dementia service levels over 2 buildings (rest home and hospital/dementia). On the day of the audit, there were 35 residents (12 of 30 beds in rest home, including 1 resident on a long-term chronic contract; 15 of 38 beds in hospital; and 8 of 19 beds in dementia care).</p> <p>The acting manager is an experienced RN who reports to the chief executive officer of Anglican Living. The acting manager has been in the role for one week. Prior to that she had been employed in the deputy manager role for four years. The acting manager is supported by three unit-managers/RNs and a quality coordinator. The acting manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</p> <p>The organisation has a current annual strategic/business plan with clearly defined and measurable goals. Goals are regularly reviewed with the board and the management team. There is a strategic plan for the facility, which includes a vision, a mission statement and core values, and a business plan 1 July 2018 – 30 June 2019.</p> <p>The prospective new owner (interviewed off-site) owns and has been managing an aged care facility for 11 years. Previous work experience includes earthquake damage assessment and 13 years as a police officer. A general manager will be employed to assist with planned refurbishments and accounts, however the current acting manager will continue and be employed as the facility manager. The new owner has a comprehensive understanding of compliance and will provide support and guidance to both. The acting manager and unit coordinators will</p> |

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|  |    | <p>remain employed under the prospective new owner, who will take on a chief executive role and provide guidance and support as required. The manager and unit managers will continue to share the on-call cover for clinical matters with the backup of the GM and CEO for non-clinical concerns.</p> <p>The expected settlement date is 21 January 2019. The DHB is aware of the pending change of ownership. The transition plan confirms there will be no changes to management or clinical systems, policies or procedures during the first year of ownership. The prospective new owner will continue current memberships with established professional bodies.</p>   |
| <p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>During the temporary absence of the facility manager, the GM, with the support of the CEO, will undertake the role of manager. The unit coordinators/RNs are also available to support the GM as required. The CEO and unit coordinators have extensive experience in aged care nursing and management.</p>  |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>                         | FA | <p>Fitzgerald Retirement Complex has a quality and risk programme that is being implemented and includes quality goals for 2018, for example around falls reduction, introduction of intentional rounding and development of self-learning education packs. Policies and procedures are maintained by a recognised aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements. Staff confirmed they are made aware of any new/reviewed policies. The service employs a quality coordinator for two days a week. Progress with the quality and risk management programme is being monitored through monthly quality/health and safety meetings and general staff meetings. Unit managers attend these meetings and feedback to their own areas. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Resident meetings are held bi-monthly and provide residents with a forum for feedback on the services. Data is collected on complaints, accidents, incidents, infection control and restraint use. The</p> |

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|  |           | <p>internal audit schedule for 2017 has been completed and 2018 is being implemented. Areas of non-compliance identified at audits have been actioned for improvement. The service has a quality improvement focus. Residents and relatives are surveyed annually to gather feedback on the service provided (with positive results) and the outcomes are communicated to residents, staff and families. The quality coordinator identified there has been a low response of relatives/residents to participate in the 2018 annual survey, however overall results identify satisfaction with all aspects of service delivery.</p> <p>A health and safety representative (one property manager) was interviewed about the health and safety programme. Four health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. A review of the hazard register indicates that there is resolution of issues identified.</p> <p>Interview with the prospective owners confirmed the current quality management system and performance monitoring programme will continue following the sale. The manager will help mentor the prospective owner to the quality risk system during the transition period. There are no planned changes to the current policies and procedures.</p> |
| <p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>There is an incident reporting policy that includes definitions and outlines responsibilities. The service collects incident and accident data and analyses falls according to time, resident service level and location of fall. Monthly collation includes graphs and trend analysis. These are reported and discussed at monthly staff and quality meetings.</p> <p>Fifteen accident/incident forms (ten unwitnessed falls, one witnessed fall, three skin tears and one other) for the months of October and November 2018 were reviewed. All document timely RN review and follow-up including neurological observations as required. There is documented evidence the family had been notified of incidents/incidents.</p> <p>There is evidence of DHB notification following two gastroenteritis</p>  |

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|  |    | <p>outbreaks in 2018. Section 31 reports have been completed for three pressure injuries in 2018. Police have been notified of three incidents, all of which were addressed satisfactorily. There has been coroner involvement regarding a resident death.</p>  |
| <p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Nine staff files were reviewed (three unit-managers, four healthcare assistants, one housekeeper and one diversional therapist) and included all appropriate documentation. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff.</p> <p>A comprehensive in-service education calendar is implemented and exceeds eight hours annually and has covered appropriate topics. The RNs attend external training including seminars and education sessions with the local DHB. A competency programme is in place with evidence of annual medication competencies for the RNs and senior healthcare assistants. Core competencies are also completed for all staff relating to fire and emergency plans. Twenty-three of twenty-four healthcare assistants who work in the dementia unit have completed the required dementia standards. A new staff member who has worked in the area for less than 18 months has commenced her dementia standards training.</p> <p>There are six RN's (including three-unit coordinators) and all are interRAI trained.</p> |
| <p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>       | FA | <p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. Families/whānau and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines</p>   |

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|  |           | <p>that the unit managers or the manager will be on call at all times. The manager and the unit managers work full-time.</p> <p>In the hospital (15 residents), there is a unit manager/RN on duty on the morning and an RN on afternoon shifts and night shift. The RNs are supported by three HCAs (two full and one short shift) on duty in the morning shift, three HCAs (two long and one short) in the afternoon shift and two HCAs at night.</p> <p>In the rest home (12 residents), there is a unit coordinator/RN who covers the morning shift Monday-Friday. A senior healthcare assistant is on duty on afternoon and night duty and also on morning shifts at the weekends. The RN and senior healthcare assistant are supported by two HCAs (one long and one short) on duty in the morning shift, one HCA in the afternoon shift and one HCA at night. The management team provide on call cover after hours and the hospital RN can be contacted at any time.</p> <p>The dementia unit (eight residents) has a unit coordinator/RN who covers the morning shift Monday - Friday. A senior healthcare assistant is on duty on afternoon and night duty and also on morning shifts at the weekends. The RN and healthcare assistant is supported by one HCA on duty in the morning shift, and one HCA in the afternoon shift. The RN from the hospital is available at any time and after hours on call cover is provided by the management team.</p> <p>The prospective owner stated household staff, the manager and some of the RNs will transfer to the new owner on the date of settlement. The new owner will be on site two weeks beforehand and work with the existing manager re employing sufficient staff to maintain safe roster practises. There are currently excessive staff numbers as Anglican care has been honouring their contracts. All others will be made redundant but offered the opportunity to apply for vacant positions.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other</p>   |

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|  |    | residents or members of the public.   |
| <p><b>Standard 1.3.1: Entry To Services</b></p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs for each service level are provided for families and residents prior to admission. The information pack for dementia level of care contains relevant information relating to a secure unit. Eight admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.   |
| <p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>                            | FA | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.   |
| <p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>              | FA | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs and senior healthcare assistants) have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The RN checks incoming medication blister packs against the electronic medication chart. A medication verification form is signed when the packed have been checked. An impress stock including antibiotics is maintained for hospital level residents. Medications were stored safely in each of the three units. Expiry dates are checked by the RN. All medications were within the expiry dates. Eyedrops and creams were dated on opening. Medication fridge temperatures were monitored and recorded daily. Standing orders are not used. No residents were self-medicating.</p> <p>All 12 medication charts reviewed on the electronic medication system met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. All medications had been administered</p> |

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|   |    | as prescribed. There were photographs, and allergy status identified on the medication charts.  |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>The food service is contracted to provide all meals at Fitzgerald. Meals are prepared and cooked on-site by a qualified chef kitchen manager who is supported by a weekend cook and kitchenhands. The dietitian has reviewed the four-weekly spring/summer menu September 2018. The kitchen is adjacent to the rest home dining room and meals are served from the kitchen bain marie to the residents. Residents in the rest home have buffet breakfasts. Food in bain marie pots are delivered in hot boxes to the hospital and dementia unit kitchenettes where meals are served by care staff. The light midday meal and main evening meal offer menu options. Each unit completes a daily menu order. The chef receives resident nutritional profiles and is notified of any dietary changes. Dislikes are accommodated. Pureed and mince/moist meals are provided. Nutritional snacks are available 24 hours in the dementia unit.</p> <p>Freezer and chiller temperatures are taken and recorded daily. Kitchenette fridges are monitored, and daily records were sighted. End-cooked food and serving temperatures are recorded on the midday and evening meals. All perishable goods were dated, as were the dry goods in the pantry. The dishwasher rinse and wash cycle temperature is taken and recorded daily. The chemical provider completes a monthly function check on the dishwasher. A cleaning roster is maintained for cooks and kitchenhands. All staff have completed training in food safety and hygiene. The food control plan has been verified April 2018 and the service also has had an external verification completed which expires September 2019. The service provides meals to another aged care facility and a specialised van is used to transport the meals to the other facility and the Fitzgerald hospital and dementia unit building.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</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 RN completes an initial assessment on admission, including the Robinsons acuity assessment, clinical risk assessment and applicable risk assessment tools. An interRAI assessment is undertaken within 21 days of admission, six monthly, or earlier due to significant changes in health. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident (as appropriate), family and significant others. InterRAI assessments, assessment notes and summary were in place for all resident files sampled. The long-term care plans in place reflected the outcome of the assessments. Behaviour assessments had been completed for the two dementia files reviewed.</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>Resident care plans reviewed were resident focused and individualised. All identified support needs as assessed, were included in the care plans for all resident files reviewed. The outcomes of interRAI assessments link with the long-term care plan supports and interventions. Behaviour management plans were in place with de-escalation strategies including a 24-hour activity plan that identifies the resident's pattern of behaviour over 24 hours. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were notified of an upcoming MDT review and were involved in the care planning process. Resident files demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist and dietitian.</p> |

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| <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>  | <p>FA</p> | <p>When a resident's condition alters, the registered nurse initiates a review and if required, GP, dietitian or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the resident family/whānau contact sheet held in the resident file.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for seven residents (four hospital and three rest home) with skin tears/abrasions. There were no pressure injuries. There was pressure injury prevention equipment readily available to minimise pressure injuries. The service has access to the Nurse Maude wound nurse specialist if required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, re-positioning, food and fluid intake, and challenging behaviour.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The service has a qualified diversional therapist (DT) who oversees four lifestyle facilitators (three permanent and one casual), who coordinate and implement the activity programme. There is one lifestyle facilitator in each unit during the week and one in the weekends who spends time in each unit. The DT is actively involved in the programme, spending three days in the hospital, one day in the rest home and one day in the dementia unit each week. The programme is planned a month in advance and reflects the cognitive and physical abilities of the groups of residents. Care staff assist residents to attend activities of their choice</p>  |

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|  |           | <p>within their unit or to a combined activity as observed on the day of audit, with dementia care residents attending bowls in the rest home.</p> <p>Each unit programme reflects meaningful activities such as baking, gardening, household tasks, garden walks, and in the dementia unit there is a blokes shed. One-on-one activities such as individual walks, massage, reading, arts and crafts occur for residents who are unable to participate or choose not to be involved in group activities. Celebrations and themes are celebrated with a showtime theme for November which included Melbourne Cup day, NZ Trotting Cup day and their own upcoming dog show to be held within the spacious and safe dementia care garden area. Activities provided are appropriate to the needs, age and culture of the residents.</p> <p>The DT interviewed, displayed an understanding of the recreational requirements across the three service levels. There are several volunteers involved in the programme who assist with hand care, housie, Tai Chi, play the piano, sing-a-longs, garden walks, chats and reminiscing and go on outings. There are two wheelchair hoist vans and regular outings to places of interest within the community, including concerts at the Woolston Club, library, gardens, parks and beaches, shopping and visits to the early learning centre. All of the activity team have current first aid certificates and there are two staff on every outing. Community visitors include entertainers and pre-school visitors. There are twice weekly Anglican church services and afternoon teas with the hospital chaplain.</p> <p>An activity assessment, map of life and activity plan are completed on admission in consultation with the resident/family (as appropriate). Activity plans in all files were reviewed six monthly.</p> <p>There is an opportunity for residents and families to provide feedback and suggestions for the programme through meetings, surveys and one-on-one feedback. Residents and relatives interviewed on the day of audit commented positively on the activity programme.</p> |
| <p>Standard 1.3.8: Evaluation<br/>Consumers' service delivery plans are evaluated in a</p> | <p>FA</p> | <p>Long-term care plans have been reviewed at least six monthly or earlier for any health changes against the resident goals. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing</p>   |

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| <p>comprehensive and timely manner.</p>   |           | <p>evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans. Family are invited to the MDT meetings and if unable to attend are informed of changes to the care plan as documented in the family contact sheet. The care staff, DT and physiotherapist are involved in the MDT meeting.</p>  |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | <p>FA</p> | <p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>  |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>                      | <p>FA</p> | <p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. There is an external locked chemical room where chemicals are delivered and stored until required. There is a chemical pre-mixing system in place. Chemical bottles sighted have correct manufacturer labels. Safety data sheets and product information is readily available. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. There are sluice rooms in each unit with appropriate personal protective wear available.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>  | <p>FA</p> | <p>There are two separate buildings. Holdsworth House is a 30-bed rest home facility. The 38-bed hospital unit and 19 bed dementia unit are in Fitzgerald House. Both buildings have a current building warrant of fitness that expires 1 April 2019. A full-time maintenance property manager is responsible for the daily maintenance and planned maintenance across both buildings and the retirement village complex. He is supported by a part-time maintenance person who also does the gardening. Maintenance logs in each unit (rest home, hospital and</p>   |

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|   |           | <p>dementia care) are checked daily for any maintenance requests or repairs. There is a weekly, monthly and annual planned maintenance schedule that includes internal and external building maintenance, resident related equipment such as wheelchairs, hoists, electric beds and handrails, testing and tagging of electrical equipment and calibration of clinical equipment. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were below 45 degrees Celsius. The service has recently installed a modern call bell system includes a pager system with additional feature of notifying management if bells unanswered for too long. The service has addressed previous issues around bell response times.</p> <p>The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids. There are safe ramps and rails to access the outdoor areas. Seating and shade are provided in the outdoor courtyards at both buildings.</p> <p>Residents in the dementia care unit (Hiron-Trinity) have safe access to the two large garden areas which are connected by walking pathways. There are several entry/exit doors from the unit to the outdoors. One large garden area has a blokes shed and raised garden and vegetable beds and seating and shade. The other large garden area has natural shade provided by trees and has seating available.</p> <p>The care staff and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans such as hoists, pressure prevention resources, platform scales and electric beds.</p> <p>The prospective owner has plans to upgrade to a new reception area and complete refurbishment of all areas.</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>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are both shared ensuites and communal use bathrooms/toilets in the hospital and the rest home building. Rest home studio rooms have ensuites. In the dementia care unit all toilet/shower facilities are communal. All resident rooms have hand basins. Communal facilities have a system that indicates if it is engaged or vacant. Privacy curtains are in shower rooms. Residents interviewed</p>  |

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|   |    | stated their privacy was respected when staff were attending to their personal hygiene needs.  |
| <p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>  | FA | <p>At present all rooms in the rest home and dementia unit are single. There are two double rooms in the hospital unit. All rooms have adequate space to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. Studio rooms in the rest home have doors that open out to gardens. This is evident during the tour of the facility.</p>  |
| <p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>Communal areas within the facility include a lounge and dining area with kitchenette in each unit along with additional smaller lounges/family rooms and seating alcoves. Seating and space are arranged to allow both individual and group activities to occur. The lounge/dining doors open out to the grounds. All furniture is safe and suitable for the residents.</p>   |
| <p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>                     | FA | <p>All personal clothing and linen are laundered off-site by a contracted service. There is daily pick-up of dirty laundry bags from an external garage and drop-off of clean linen and clothing into the hospital clean folding room for sorting and distribution to resident rooms and linen storage areas in each unit. On the day of audit there were adequate linen supplies. A household person is employed to collect the dirty linen bags from each unit to the collection point. They also sort, fold and iron personal clothing as required. All woollens and delicates are washed on-site in the hospital domestic laundry. All kitchen washing is done by food services in their laundry room.</p> <p>Household cleaners in each unit have well equipped cleaning trollies that are kept in locked cleaners' cupboards when not in use. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Residents and relatives interviewed were happy with the laundry service and the cleanliness of</p> |

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|   |    | their rooms.   |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>   | FA | <p>There are emergency procedures in place at both buildings to guide staff should an emergency or civil defence event occur. There are first aid trained staff across all shifts. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted. Fire evacuation drills are completed six monthly. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Emergency equipment is available. Civil defence wheelie bins situated in each area (hospital, rest home and dementia) are available (sighted). The staff confirmed that they have civil defence equipment including alternative cooking methods (gas supplied to the kitchen and barbeques). Gas heaters are available if required.</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>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The wall heating in each room can be individually controlled. Communal areas have ceiling heating.</p>  |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practices and reporting. The rest home unit manager is the infection control coordinator and is responsible for infection control across the facility. An external aged care consultant is responsible for the development of the infection control programme and its review. The infection control programme is well established at the facility. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners and public health.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. There have been two outbreaks since the last audit.</p> |

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|  |    | Both outbreaks were well managed and public health were notified.  |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>  | FA | There are adequate resources to implement the infection control programme. The infection control coordinator has maintained best practice by attending external infection control seminars. The infection control team is representative of the facility. There is access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics. Infection prevention and control is part of staff orientation and ongoing annual education schedule. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| <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 infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant and reviewed regularly.  |
| <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 | The infection coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to): outbreak management (March and May 2018) and infection control and food handling (August 2018).  |
| <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 surveillance policy describes the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as  |

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|  |           | <p>part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly and reported at the various facility meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. A review of outbreak management occurred following two recent outbreaks in 2018.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Fitzgerald complex has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The hospital unit manager/RN is the restraint coordinator. On the day of the audit there were no residents on restraints or enablers. The restraint coordinator confirmed that the service promotes a restraint-free environment. Restraint education is included in the two-yearly training programme and last occurred in April 2018. The service has been restraint free for over four months.</p> <p>The prospective owner is familiar with restraint standards and has good understanding of restraint minimisation and safe practise.</p>  |

## Specific results for criterion where corrective actions are required

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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.

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## Specific results for criterion where a continuous improvement has been recorded

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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.