

Sandringham House Limited - Sandringham House Rest Home

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

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

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

The specifics of this audit included:

Legal entity:	Sandringham House Limited
Premises audited:	Sandringham House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 November 2018 End date: 21 November 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:	19

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

Indicator	Description	Definition
	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

Sandringham House Rest Home is a privately-owned service that provides rest home level care for up to 21 residents. On the day of audit there were 19 rest home residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

There are two owners; one is the nurse manager and the other is responsible for finance, office administration and maintenance. The nurse manager is supported by a registered nurse.

The service has an established quality and risk management system. Residents and families interviewed commented positively on the standard of care and services provided.

The service has addressed the one previous audit shortfall around observations.

This audit has identified no further areas required for improvement.

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.
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Care plans accommodate the choices of residents and/or their family. Informed consent processes are implemented and documented. A culture of open disclosure is encouraged with family interviewed, reporting they can speak to management or the registered nurse and that they are fully informed of the resident's condition and progress, including any incidents or changes in health status. Complaints processes are implemented and managed in line with the Code.

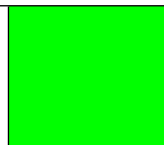
Organisational management

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.
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Sandringham House has a documented quality and risk management system that supports the provision of clinical care. Quality data is collated for infections, incidents, internal audits, concerns and complaints, and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

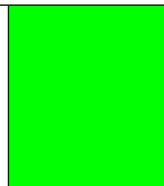


Standards applicable to this service fully attained.

Care plans are developed by the clinical manager and registered nurse who also maintain and review care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

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.

The building has a current warrant of fitness. There is a current maintenance plan and all maintenance was up to date at the time of audit. Calibration of medical equipment occurred. The hot water temperatures are monitored monthly. There is sufficient room for residents to move around the facility with mobility aids. All external areas are well maintained.

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.
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Sandringham House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. There were no residents with restraints or enablers.

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.
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Surveillance is undertaken and used to determine quality assurance activities and education needs for the facility. The infection rate is very low.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 owner manager leads the investigation of any concerns/complaints. Sandringham House has compliments, suggestions and complaints available at reception. The service has responded appropriately to one complaint received in 2017 and one in 2018. A recent health and disability complaint is currently being investigated and the service has responded in a timely manner for all requests for information within the required timeframes. The complaints register is up-to-date. Management operate an 'open door' policy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Five residents interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. A review of 12 incident forms for October and November 2018, identified family were notified following a resident incident/accident. The RN interviewed confirmed family are kept informed. The four relatives interviewed confirmed they are notified promptly of any incidents/accidents. Family members and residents interviewed advised that they are encouraged to discuss any concerns with the owner manager and/or registered nurse. The service has access to an interpreter service.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Sandringham House Rest Home is a privately-owned service that provides rest home level care for up to 21 residents. On the day of audit there were 19 rest home residents all under the age-related residential care services agreement.</p> <p>There are two owners; one is the nurse manager and the other is responsible for finance, office administration and maintenance. The nurse manager is supported by a part-time registered nurse (who works three days per week) and care staff.</p> <p>The goals and direction of the service are documented in the business plan and progress toward goals has been documented.</p> <p>The nurse manager has completed eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The fully implemented quality system utilises an external quality and risk management system facilitated by the nurse manager. Key components of service delivery are linked to the quality and risk management system including resident satisfaction, internal audits, the management of adverse events, restraint minimisation and infection prevention and control. Corrective action plans are developed, implemented and signed off when service shortfalls are identified.</p> <p>The quality system includes policies and procedures that are relevant to the service types offered. These are reviewed and updated at least two-yearly or sooner if there is a change in legislation, guidelines or industry best practice.</p> <p>The staff/quality meeting is where information on quality and risk management is conveyed to staff, as well as via handover sessions. Meeting minutes and staff interviews informed that all aspects, including numbers of incidents by category, are discussed at each meeting.</p> <p>The service maintains a current risk register. Health and safety policies are current and reflect current legislation. There is a designated health and safety officer. Health and safety actions, including discussion in meetings of issues and documentation of a hazard register specific to the service are documented.</p> <p>There are resident/relative surveys conducted and analysed. The April 2018 resident/relative survey evidenced an overall satisfaction rate of 100%. Falls prevention strategies are in place for individual residents.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>A sample of 12 accident/incident forms for October and November 2018 were reviewed. All incident reports and corresponding resident files evidenced appropriate clinical assessment, including neurological observations where required were completed within a timely manner. This is an improvement on the previous audit. Accidents/incidents were recorded in the resident progress notes. There was documented evidence the family/whānau had been notified promptly of accidents/incidents.</p> <p>The service collects incident and accident data and reports actual numbers to the staff meetings. Staff interviewed, confirmed incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Six staff files sampled (nurse manager, one registered nurse, the activities coordinator, the cook and two caregivers) contained all relevant employment documentation. Current practising certificates were sighted for the RNs, and allied health professionals.</p> <p>Performance appraisals were up-to-date. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>There is an annual training plan in place and implemented. Staff training is provided at least monthly and all core subjects have been covered in the programme in the past two years. Residents stated that staff are knowledgeable and skilled. The nurse manager is interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The roster provides sufficient and appropriate coverage for the effective delivery of care and support. There is nurse manager on duty Monday to Friday, with another RN three days per week. On-call is managed on a rotating roster between the nurse manager and the registered nurse.</p> <p>On morning shift, one caregiver works 7.00 am to 3.00 pm and a cook caregiver role works from 6:30 am to 3:00 pm. On afternoon shift one caregiver works 3.00 pm to 11:00 pm and a cook caregiver role works from 3.30 pm to 7:00 pm. There is one caregiver on duty overnight.</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>Activities hours are 1:20 pm to 3:00 pm five days a week. Staff and family interviewed reported that staffing is sufficient, and that management are visible and able to be contacted at any time.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The service uses an electronic prescribing and administration system. All residents have individual medication orders with photo identification and allergy status documented. The service uses a blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the staff with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed in the electronic system each time a medicine was administered by staff. A caregiver was observed administering medications and followed correct procedures. There was no resident's self-medicating at the time of audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food service standards continue to be maintained. All food is prepared and cooked on-site. There are two cooks who provide cover over the week. They have completed NZQA food safety units. There is a caregiver on duty in the afternoons for the evening meal. There is a four-weekly rotating menu that has been reviewed by a dietitian. The meals are served from the kitchen directly to residents. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated. The meals are well-presented, and residents confirmed that they are provided with alternative meals as per request. Lunchtime was observed, and staff were observed assisting residents as needed. A food control plan is in the process of verification.</p> <p>Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. A cleaning schedule is maintained. All residents are weighed monthly, and any identified weight loss is addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>FA</p>	<p>Comprehensive care plans were documented for all five resident's files reviewed. The service has implemented a new care planning template that links to the interRAI headings. When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.</p>

<p>assessed needs and desired outcomes.</p>		<p>Wound assessment, wound management and evaluation forms are in place for the one resident with a wound. Wound monitoring occurred as planned. The facility has access to wound care specialist advice if required.</p> <p>Resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities coordinator has been in the role for four years and works 20 hours a week. Each resident has an activities assessment (social history) and care plan, there are six monthly evaluations and attendance sheets for all activities. The activities plan links to the interRAI assessment, with evaluations reflecting individual resident goals and progression towards meeting goals.</p> <p>Activities are posted weekly on the noticeboard. Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>On the day of the audit, residents were observed being actively involved with a variety of activities. The activities programme includes residents being involved within the community with social clubs, churches and schools. Activities include (but are not limited to): newspaper reading, housie, happy hour, speakers, van rides, pet therapy, games and visiting entertainers. The facility has its own van which is used for activities and resident transportation.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The interRAI assessment is undertaken at least six-monthly or if there has been a significant change in their health status. Long-term care plans documented a written evaluation and were updated at least six monthly. There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months), or when requested if issues arise or their health status changes. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>The building has a current warrant of fitness which expires 26 August 2019. The co-owner (spouse to the nurse manager) coordinates and undertakes maintenance. There is a maintenance book for staff to record any maintenance/repairs/replacements required and this is signed off once completed. There is a current maintenance plan. Calibration of medical equipment occurs annually. The hot water temperatures are monitored monthly. Review of the records reveals water temperatures of 45 degrees Celsius and when out of range, corrective actions have been recorded. There is sufficient room for residents to move around the facility with mobility aids. All</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>external areas are well maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided.</p> <p>Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator (nurse manager) collects the infection rates each month. The infection rate is very low. The data is analysed to identify trends and determine infection control quality initiatives and education within the facility. Infection control data is communicated to staff and management through meetings. Care staff interviewed were knowledgeable about infection control practices. There have been no outbreaks since the previous audit.</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>The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. Staff have been trained in the management of behaviours that challenge.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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, there 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.