

Springvale Manor Limited - Springvale Manor 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:	Springvale Manor Limited
Premises audited:	Springvale Manor Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 14 March 2019 End date: 15 March 2019
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:	24

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

Springvale Manor rest home is privately owned and governed by three directors. The rest home provides rest home level of care for up to eight residents and dementia level of care for up to 20 residents. On the day of the audit there were 24 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant 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.

One owner/director is the manager and she is supported by one full-time registered nurse, one full-time enrolled nurse, two part-time enrolled nurses and long-serving staff. The residents and relatives commented positively about the services, care and environment provided at Springvale Manor rest home.

All three previous findings relating to family notification of incidents, documentation of quality data in meeting minutes and completion of registered nurse orientation have all been addressed.

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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Communication with residents and families is appropriately managed and recorded. There is a documented complaints process.

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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The service continues to implement a quality and risk management programme that includes management of incidents, complaints and infection control data. There is an implemented internal audit programme to monitor outcomes. There is an appropriately experienced owner/manager who provides guidance for the service and is supported by a registered nurse (RN) and enrolled nurse (EN) who work full-time. The RN and EN provide clinical oversight during weekdays and are available afterhours. There is an in-service training schedule. The service has sufficient staff allocated to enable the 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.
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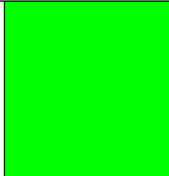
The registered nurse and enrolled nurse are responsible for the assessments, care plan development and evaluations. The interRAI assessment is being utilised to inform the care plans. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration. Care plans are evaluated six monthly or more frequently when clinically indicated. The general practitioner reviews the residents at least three monthly.

A diversional therapist and activity assistant provide an activity programme for both areas (rest home and dementia care) to meet the needs of both groups of residents. Healthcare assistants are involved in implementing the programme in the dementia care unit. Each resident has an individualised plan. Residents are encouraged to participate in community activities. There are regular drives and outings for all residents.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff responsible for administering medications complete annual competency assessments.

Meals are prepared in the kitchen by qualified cooks. Individual and special dietary needs and dislikes are accommodated. There are nutritious snacks available at all times. Residents interviewed responded favourably about the food that was provided.

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.
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The facility has a current building warrant of fitness.

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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The service has policies and procedures that meet the definitions of enablers and safe use of restraint. There were no residents using enablers and two residents with a restraint in place. An enrolled nurse is the restraint coordinator. Staff receive annual training around restraint, challenging behaviours and de-escalation techniques.

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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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (enrolled nurse) is responsible for collating infection control data and communicating information to the management and staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	39	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>The service has a complaints policy that describes the management of the complaints process. The owner/manager is responsible for complaint investigations and advised that she responds to complaints. There have been no complaints made since the last audit. A complaint register has been maintained (last complaint August 2017). Complaint forms are available at the entrance of the service. Information about complaints is provided on admission. Care staff interviewed were able to describe the process around reporting complaints. Residents and family members interviewed stated that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>The owner/manager or the RN or EN welcome residents and families on entry and explain about services and procedures. Five residents/relatives interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. There is an open disclosure policy in place, information on which is included at the time of admission. Incident and accident forms are completed by HCAs and other staff members, clinical follow-up is completed by the RN and signed off by the owner/manager. Seven incident forms reviewed for February 2019 identified six families were notified following a resident incident (the family of the seventh had put conditions onto when and for what they wished to be notified and the incident did not fall into this). The finding from the previous audit is now met. Two relatives (one dementia level, one rest home) interviewed, stated that they were informed when their family member's health status changed.</p>

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>Springvale Manor Limited is the proprietor of Springvale Manor. Three directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. The directors meet three monthly. The manager/owner is able to describe the company financial and business goals. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2019 business plan that outlines objectives for the period, a particular focus being on giving the best possible care and remaining financially viable.</p> <p>Springvale Manor provides rest home and dementia level care for up to 28 residents (eight rest home and 20 dementia beds). On the day of audit, there were four rest home residents and 20 residents in the secure dementia unit. All residents are under the ARCC contract.</p> <p>The owner/manager (non-clinical) works full time and has been in the position for approximately ten years. She is supported by an RN and an EN who each work 40 hours per week. The registered nurse has recently commenced, and the enrolled nurse has been at the facility for two years.</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 quality manual and the business, quality and risk management planning describe Springvale Manor's quality improvement processes. Policies and procedures are developed by an external consultant and the manuals are updated when policies have been reviewed. Springvale Manor continues to implement an internal audit programme that includes clinical and non-clinical aspects of the services. Issues arising from internal audits are documented as corrective actions. Review of documents and staff interviews confirmed this. Discussions with the RN, EN, diversional therapist and HCAs confirmed their involvement in implementation of the quality programme. A resident and relative survey was completed in July 2018 and shows satisfaction with services provided.</p> <p>Springvale Manor has a health and safety management system. There are implemented risk management, health and safety policies and procedures including accident and hazard management. Monthly accident/incident reports and infection control surveillance data were completed. The service communicates relevant information to staff - review of meeting minutes evidenced this. The previous finding has been addressed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	FA	<p>Springvale Manor documents and analyses incidents/accidents, unplanned or untoward events. A sample of seven incident reports for February 2019 were reviewed. Incident and accidents were reported to the RN/EN and the owner/manager for action if required. Incidents/accident forms were all signed off by the owner/manager. Staff interview (three HCAs, the EN and RN and the diversional therapist) confirmed active involvement in management of risks. Discussion with the owner/manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service initiates re-assessments for residents requiring a</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>higher level of care.</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>Human resource management policies are implemented. Professional qualifications are validated as part of the employment process. Copies of professional practicing certificates are held on site for the RN, EN, the GP and the pharmacist. Six staff files were reviewed (one RN (employed February 2019 orientation complete), one EN (full-time), another EN (employed February 2019 orientation complete), one cook, one DT and one HCA). All files had employment records, completed orientation and annual performance appraisals for those that were due. The finding from the previous audit relating to incomplete orientations is now met.</p> <p>Staff receive an orientation and on-site support with a senior staff member. There is an orientation programme that provides new staff with relevant information for safe work practice. The fulltime enrolled nurse confirmed access to external training and on-line training. The RN is awaiting interRAI training. The fulltime EN undertook interRAI training in September 2018 and is supervised by an RN from the DHB CART team.</p> <p>A two-yearly education plan is implemented covering all the relevant requirements and attendance records are maintained. Staff complete competencies following in-service sessions. Six HCAs have completed the required dementia standards and three are currently in training. Eight hours of staff development or in-service education has been provided annually.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides coverage across both areas. Staffing cover is appropriate to the layout of the facility and the scope of the service delivery. Three HCAs, one RN and one EN interviewed confirmed they have appropriate staffing numbers and skill mix on their shifts. Family interviews confirmed adequate staffing. The owner/manager described low staff turnover except for RNs.</p> <p>There is one caregiver on each duty in the rest home 24 hours a day. There are two caregivers in the dementia unit on a morning and afternoon shift. The dementia unit is in close proximity to the rest home unit (through a set of doors) and the call system is interlinked. There is a caregiver in each area at night. The RN and EN work 40 hours each per week. Two other ENs work part time (one of these works the weekends). A qualified diversional therapist works 40 hours per week. The owner/manager works full time. Both the owner/manager and RN or EN are on call after hours.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN, ENs and medication administration competent HCAs administer medications and have completed annual medication competencies. An electronic medication system is used. The service uses four weekly blister packs which are checked against the medication chart by the RN. All medications are stored safely. There were no self-medicating residents on the day of audit. Standing orders are not used.</p> <p>Ten medication charts were reviewed. All medication charts had photo identification and allergy status documented. Prescribing of regular and 'as required' medication met legislative requirements. All medication charts had been reviewed by the GP at least three monthly. Administration signing corresponded with the medication chart.</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>All meals and home baking are prepared and cooked on site. The qualified cook on duty is supported by a morning kitchenhand and tea aide. Food services staff have completed food safety hygiene training. There is a four-weekly seasonal menu that has been reviewed by a dietitian (February 2019). The cook receives resident dietary instructions that includes resident dislikes and special requirements. Dislikes are accommodated. The cook is notified of any changes to resident's dietary needs or residents with any weight loss. The kitchen is adjacent to the dementia care dining room. Meals are delivered to the separate rest home dining room. Nutritious snacks are available at all times.</p> <p>Kitchen fridges and freezer temperatures are monitored daily and recorded. End cooked food temperatures are monitored and recorded daily.</p> <p>Rest home residents interviewed, and relatives commented positively on the meals provided. The Whanganui Compliance Officer Food Control had inspected the premises and food service and a Grade A was given for licensing in November 2018.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>Documentation reviewed and interviews with staff, residents and relative identified that care is being provided consistent with the needs of residents. When a resident's condition changes, the RN initiates a GP referral. There was evidence in the progress notes and on the accident/incident forms that families were notified of any changes to their relative's health including (but not limited to) accidents/incidents, infections, health professional visits and changes in medications. The relatives are welcomed by the GP to ring or meet with him. Interventions in care plans were individualised and detailed.</p> <p>Dressing supplies were sighted and are readily available for use. Wound management policies and procedures are in place. Wound assessments and ongoing wound evaluations describe the treatment, frequency of change of</p>

<p>desired outcomes.</p>		<p>dressings and evaluations of wounds. There was one resident with two wounds (one surgical and one skin tear). There were no pressure injuries. The RN and EN interviewed, described the process should they require assistance from a wound specialist.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring forms are used (including behaviour, blood glucose, pulse recordings, food and fluid) to record a resident's progress towards meeting short-term supports for 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 employs a qualified diversional therapist (DT) for 36 hours per week Monday to Friday. She is supported by an activity assistant, two days a week from 8.30 am to 3.00 pm. The activity team provides a varied programme that is flexible to meet the needs of the dementia care residents and the rest home residents. Consent is gained from rest home residents and their families to join some activities in the dementia unit such as entertainment and church services. The DT has allocated time to spend with rest home residents including one-on-one time.</p> <p>Activities offered include crafts, nail care, reminiscing, sing-a-longs, and walks. A pianist comes weekly and other entertainers 2/3 times a month. A monthly church service is held.</p> <p>A van is hired for weekly outings/drives into the community and attending social events.</p> <p>HCA's are involved in providing activities as part of their role. A sensory room in the dementia unit provides a low stimulus environment with soothing music and low lighting which reduces resident agitation and decreases episodes of challenging behaviours.</p> <p>Residents and relatives provide feedback on the activity programme through verbal feedback and six monthly multidisciplinary meetings. Residents interviewed spoke positively about the programme.</p> <p>Activity assessments are completed soon after admission. Each resident had an individual activity plan which is reviewed six monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	<p>FA</p>	<p>Three of five long-term care plans reviewed (two dementia residents had not been at the service long enough for a six-monthly evaluation) evidenced they had been reviewed and interventions changed as needed with relative/resident involvement in the care plan review. The documentation for recording the evaluations is currently being reviewed by the recently commenced RN to more direct evidence evaluations against the resident's specific goals. InterRAI assessments have been completed six monthly (with oversight by an RN from the WDHB) as part of the care plan review. There is at least a three-monthly review by the medical practitioner.</p>

timely manner.		
<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>	FA	<p>The building has a current building warrant of fitness that expires on 1 November 2020. Preventative and reactive maintenance occurs.</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>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (RN) recently left and the recently appointed RN will take up the role. In the interim the EN is the IC coordinator and is undertaking the Ministry of Health on-line training for the same. The information obtained through surveillance is collated to determine infection control activities and education needs in the facility. Monthly infection control reports are provided. The monthly infection control data report is fed back to monthly staff meetings. Definitions of infections are in place appropriate to the complexity of service provided. Internal audits for infection control are included in the annual audit schedule. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents with enablers and two residents with a restraint (one in a fallout chair and lap belt, the other with one bedside, covered.) Care plans gave clear instructions for the safe use of and monitoring of the restraints. The restraint coordinator is an enrolled nurse. Challenging behaviour and de-escalation education is included in the training programme – last covered November 2018.</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.