

Carter Society Incorporated - Carter Court 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Carter Society Incorporated

Premises audited: Carter Court Rest Home

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 21 May 2019 End date: 21 May 2019

Proposed changes to current services (if any): HealthCERT has requested the addition of a bedroom (dual purpose) created from an existing deck area, be included in this audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 34



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

Carter Court Rest Home provides rest home and hospital level care for up to 42 residents. The facility is owned and operated by Carter Society Incorporated. The facility is managed by a manager and nurse manager. Residents and families stated the care provided is of a high standard.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

An area requiring improvement relates to continuity of service delivery and updating of care plans to reflect assessed needs.


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

The manager is responsible for the management of complaints and a complaints register is maintained. An investigation by Nursing Council is currently being undertaken. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

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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Carter Society Incorporated is the governing body and is responsible for the service provided. An annual management plan including strategic goals and quality and risk management systems are fully implemented at Carter Court Rest Home. Systems are in place for monitoring the service, including regular reporting by the manager to the executive committee.

The facility is managed by a manager who has been in position for two years. The manager is supported by a nurse manager who is responsible for the clinical services. Support is provided by the executive committee.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, registered nurses, staff and residents' meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Human resources processes are followed. An in-service education programme is provided.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are rostered on duty at all times.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a range of clinical information. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by a diversional therapist and two recreation assistants. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by an enrolled nurse or registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

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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A current building warrant of fitness is displayed. A new bedroom has been created from an existing outdoor deck area.

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 clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were two residents using a restraint at the time of audit. No residents were using 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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Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	15	0	0	1	0	0
Criteria	0	38	0	0	1	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 complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and complaints information and forms are available at the main entrance. There have been two complaints since the last audit and these have been entered into the complaints register. The complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The manager is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p> <p>The manager reported there have been no complaints to the Health and Disability Commissioner (HDC) since the previous audit and no investigations by the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit. The manager reported and documentation reviewed evidenced there is an investigation currently being undertaken by Nursing Council concerning the conduct of an RN. The manager advised the RN is no longer working at Carter Court.</p>
Standard 1.1.9: Communication	FA	Residents and families stated they are kept well informed about any changes to their own or their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via the local DHB or Age Concern if required. There is also staff diversity and a number of different first languages can be utilised if needed.</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>The annual business and strategic plan 2018-2019 includes the purpose, values, scope, direction, goals of the organisation. There are four goals; accommodation and care; growing community; appropriate care and support and collaboration and advocacy. The executive committee consists of 12 members with a sub-committee of five members being the finance and audit committee. This committee meets a week prior to the monthly executive meetings. The manager physically provides a monthly report to the executive committee. Review of the reports evidenced they are comprehensive and provide information on all activities undertaken at Carter Court.</p> <p>The manager has been in the position for 22 months. Prior to this position the manager was the finance and business manager at Carter Court for seven years. The manager attends the two monthly DHB meetings and other appropriate updates. The nurse manager (NM) is a registered nurse with wide experience. Prior to this role, the NM was a clinical nurse specialist in a hospice setting. The NM is an educator and also has a masters' degree in health care -clinical and leadership from Victoria University. The NM is responsible for the clinical services and keeps up to date attending various workshops, conferences and meetings.</p> <p>Carter Court is certified to provide accommodation for 42 residents (17 dual purpose and 25 rest home only) with 34 beds occupied on the day of audit. There were 14 hospital level residents and 20 rest home level residents including one respite resident.</p> <p>Carter Court has contracts with the DHB for aged related residential care services, long term support- chronic health conditions, and short-term Residential care (respite).</p> <p>HealthCERT has been notified of the change of managers since the previous audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>The organisation has a comprehensive quality and risk management system that guides the quality programme and includes principles and quality targets for 2019.</p> <p>Quality data for incident/accidents, satisfaction surveys, internal audits, infections, pressure injuries and medication errors are being collected, collated and comprehensively analysed to identify trends. Corrective actions are developed and implemented with monitoring to make sure corrective actions have been effective. Quality, RN, staff, health and safety and resident meeting minutes reviewed evidenced regular reporting and review of data. Trends</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>are identified, including graphs that are generated month by month and hourly, which indicate what time of the day incidents/accidents are occurring. The manager demonstrated sound knowledge relating to quality and risk management. The monthly quality report reviewed is comprehensive. Staff reported they are kept fully informed and discuss quality data at their meetings including trends and what corrective actions have been put in place. Interviews of staff evidenced they are kept fully informed by the manager and nurse manager.</p> <p>Resident and family satisfaction surveys are completed annually and evidenced residents and families are satisfied or very satisfied with the services provided.</p> <p>Policies and procedures are fully embedded at Carter Court. They are relevant to the scope and complexity of the service, reflected current accepted good practice, referenced legislative requirements and refer to interRAI. Policies and procedures have been reviewed by the senior management group and are current. New / reviewed policies are available for staff with track changes initially so that they can readily see any changes. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management plan 2019-2020 is in place. Actual and potential risks are identified and documented. The hazard register includes but is not limited to clinical, environment, staffing and financial risks. The manager, who has overview of health and safety, is responsible for the management of hazards, including putting in place appropriate controls to eliminate or minimise all hazards on site. Interview with the manager confirmed this. Hazards are communicated to staff and residents as appropriate. The manager demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented the documented hazard identification processes.</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</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by the RNs, the EN and health care assistants (HCA) on hard copy forms and are reviewed by the NM. Information is entered into the electronic system including a register of all incident/accidents. The nurse manager is responsible for the development of any corrective actions and close out. Review of the register, incident/accident reports and interview of staff indicated appropriate management of adverse events.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The nurse manager stated there have been two Section 31s notified to HealthCERT for pressure injuries since the last audit. The manager reported there have been no other notifications made to external agencies.</p>

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<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures relating to human resources management are based on relevant legislation and good employment practices. Staff files reviewed included job descriptions which outline accountabilities, responsibilities and authority, employment agreements, references, completed orientation performance appraisals and police vetting.</p> <p>New staff are required to complete an induction prior to completing the orientation programme. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role.</p> <p>There is a focus on continuing education and care staff are encouraged and supported to complete a New Zealand Qualification Authority education programme. The manager and NM advised three care staff are currently completing level 4, one has recently completed level 4, five have completed level 3 and seven are currently completing level 3. There are two assessors on site at Carter Court with another currently completing the training.</p> <p>The education plan for 2019 was reviewed. Education is provided at compulsory study days and at other sessions as well. Attendance is entered into an electronic spread sheet. External educators are sourced and staff have the opportunity to attend sessions externally, following which they are expected to share the information with the rest of the staff. Registered nurses have the opportunity to attend sessions provided by the local DHB. Competencies were current, including medication competencies for the RNs and EN and HCAs as second checkers.</p> <p>Three RNs are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation. Staff also confirmed their attendance at on-going in-service education and that their performance appraisal was current.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. Currently the total number of staff employed is 50. Registered nurse cover is provided 24 hours, seven days a week. The manager advised there is a casual pool of an RN and health care assistants (HCA) who can work at short notice. The manager reported the rosters are adjusted to meet the changing needs of residents, resident acuity including interRAI, occupancy and the environment. The manager advised a 'special' will be provided if a resident's needs require this. Review of the rosters confirmed this.</p> <p>The manager and NM work full time Monday to Friday and are on call after hours. Six RNs and an EN are currently</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>employed, with another RN starting employment the week following the audit. All the RNs and EN are experienced staff who have worked at Carter Court for four months to 16 years and are experienced in caring for the older adult. There is a range of HCAs who have been working at Carter Court for timeframes varying from many years to several months.</p> <p>Residents, families, staff and the GP interviewed demonstrated satisfaction with the staffing levels.</p> <p>There are dedicated cleaning staff and laundry staff. A divisional therapist is employed Monday to Friday with a casual person on call for resident outings. Maintenance is contracted out. The kitchen has cooks and kitchen hands who cover the allocated hours, seven days a week. A administrator and receptionist work Monday to Friday.</p> <p>Observations during the audit confirmed adequate staff cover is provided, including residents being helped with meals in a timely manner. The addition of a new bedroom has not impacted on staffing levels.</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 policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administered medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and Nurse Manager (NM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any</p>

		<p>medication errors, and compliance with this process was verified.</p> <p>Standing orders are used and meet standing order guidelines.</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>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian on 1st June 2018. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A food control plan is in place and registered with the Carterton District Council. The expiry date of the Food Control Plan is the 5th of March 2020.</p> <p>A verification audit of the food control plan has been undertaken. The verification report dated 6th June 2018 identifies the verification outcome as unacceptable, with five corrective actions being required to be undertaken by 7th May 2019. The FM confirms these have been addressed, though no verification of this by the council has been received. An email received from the Council, on the day of audit, advised that a new Food Control Plan, would not have been issued if the corrective actions had not been attended to.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. On the day of audit there are enough staff observed on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. Evidence verifies this staffing is consistent each day.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	FA	<p>Apart from that documentation referred to in criterion 1.3.3.4, documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Residents and family members were very complimentary of the high standard of care and attention provided by the staff of Carter Court rest home. Prompt referrals were initiated when specialist services were required. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>standard. Care staff confirmed that care was provided as outlined in verbal handovers and directions from senior clinical staff, in addition to the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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 programme at Carter Court rest home is provided by a qualified diversional therapist, with the assistance of two recreation officers and several volunteers seven days a week; as well as involvement from the facility dog.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated regularly, at the monthly residents' meetings, after every event and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. On the day of audit, observation revealed a wide range of different activities going on, assisted by several local volunteers. The environment is a hive of activity. The presence of the visiting pre-school group sees residents assisting the children in performing their action songs. The activities on offer reflect residents' interests, goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. A weekly outing for the men to the local men's shed, enables the men to keep contact with local events, and maintain their DIY skills. Examples of other regular events include Tai Chi, visiting entertainers, quiz sessions, regular outings, visits to community events, places of interest and daily news updates. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>A building warrant of fitness is displayed that expires on the 30 June 2019. A new bedroom has been created from an existing deck area and is part of an existing wing. The room is large with a one and a half leaf door. An electric heater and call bell are provided. Amenities are close, with a toilet next to the bedroom and a shower room and another toilet adjacent. A code of compliance certificate from the local authority was sighted dated 13 November 2018 for the new bedroom. The new room is fit for purpose and increases the dual-purpose rooms from 16 to 17.</p> <p>There is an approved evacuation scheme in place and a letter from the NZ Fire Service was sighted stating that the addition of the new bedroom has no impact on the current evacuation scheme.</p> <p>The manager advised an additional six beds (dual purpose) is planned as an extension to one of the wings (Bill Monk Wing). The manager advised the timeframe for this extension is thought to be 2020.</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>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than only on laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control nurse and NM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via monthly reporting to quality and staff meetings and at staff handovers. An annual infection control Clinical Governance Report is produced that identifies trends for the current year, and comparisons against previous years.</p> <p>There have been no Norovirus outbreaks at Carter Court rest home within the past three years.</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 restraint minimisation policy has a section on enablers that includes a definition, assessment and evaluation. The NM reported the aim is to have no restraint. There were two residents using a restraint at the time of audit and no residents using an enabler. Although there was documentation specific to restraint use in the residents' files, their care plans did not include any information relating to the use of restraints. (See link to corrective action in 1.3.3.4).</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Systems are in place to promote continuity of care, such as detailed progress notes, a verbal handover at the start of each shift, and written handover sheets. However, seven of eight resident files reviewed did not have documentation in the care plan (either the long-term care plan or a short-term care plan) that described fully the nursing care required to address all aspects of the resident assessed needs.</p> <p>Potential risks related to prior medical events, past medical history and medication changes had no nursing strategies documented to ensure monitoring of improvements or potential deterioration.</p> <p>Two residents using restraint had no documentation in the care plan, which identified the resident was using a restraint or the management strategies required to manage the individualised risk associated with the restraint (all other required documentation and interventions around the restraint was being attended to).</p> <p>A resident on an intensive pain management regime, had no documentation in the care plan the identified the resident had pain, and the required strategies to ensure comfort, despite evidence being verified that the resident’s pain was being managed very well.</p> <p>A resident with behaviour concerns which were well documented in progress notes, had no documentation verifying the management strategies that were being implemented. A</p>	<p>The documentation in the care plans reviewed, did not fully describe the care the resident required to meet their assessed needs.</p>	<p>Provide evidence that the documentation in the care plan is reflective of the resident’s need, to enable a coordinated approach and continuity of care.</p>

		<p>recent event, requiring prompt input from specialist services, had no documentation identifying the interventions implemented, following the advice received. Interviews with care staff confirm the required interventions are being implemented however acknowledge this is not always documented. The nurse manager verified that documentation audited did not reflect fully residents care needs.</p>		90 days
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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.