

# Tui House Limited - Tui House

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## 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 Q-Audit 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:

<b>Legal entity:</b>	Tui House Limited
<b>Premises audited:</b>	Tui House
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 October 2019      End date: 15 October 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	55

# Executive summary of the audit

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## Introduction

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

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

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

### 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

Tui House is an aged care residential facility and is privately owned and operated by Heritage Healthcare Limited. The facility consists of two adjacent houses on one site, Tui House (30 beds) and Cecelia House (21 beds), plus 12 stand-alone units of 19 beds, a total capacity of 70 beds.

The owner/general manager (GM) is a registered nurse who is actively involved in the business.

This surveillance audit was undertaken to confirm continuing compliance with the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included review of policies, procedures, residents and staff files, observations and interviews with residents, family/whanau, management, staff and the general practitioner (GP). Residents and family members interviewed expressed satisfaction with the care and services provided.

Three areas identified as requiring improvement at the last audit have been addressed and maintained. There were two areas identified for improvement during this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Resident records are maintained as required. The complaints management system is readily accessible and managed in compliance with the Code of Rights.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Tui House strategic plan has been updated by the GM with input from the members of senior management. The annual business plan and strategic goals reflect organisational planning outcomes.

The owner/registered nurse, the facility manager and the clinical nurse manager are experienced in aged care and have maintained relevant education and training.

The documented quality and risk management system has been maintained up to date and supports the provision of clinical care. Clinical protocols continue to reflect current good practice and policies meet legislative requirements.

Quality and risk performance outcomes are reported and monitored by the organisation's senior management team. The program of internal audits has been maintained and used to identify areas for improvement. Corrective action planning is implemented to manage any areas of concern or deficits. Review of service delivery includes incidents/accidents, infections, complaints and trended data reports from the internal audit programme.

The adverse event reporting system ensures that staff document and report all adverse, unplanned or untoward events. A process to correct deficiencies and prevent recurrence is implemented.

Sound human resources practices are implemented. Staffing allocation levels and skill mix are appropriate to the layout of the facility and the services provided. The scheduled program of staff orientation, on-going education, competency verification and performance appraisals has been maintained.

## 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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Residents are assessed prior to entry to the service to confirm their level of care. The process for assessment, planning, provision, evaluation, review and exit is provided by the registered nurses (RNs). InterRAI assessments and individualised care plans were developed and completed within the required timeframes.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP). The organisation uses a paper-based medication system. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met.

## 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.



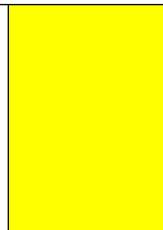
Standards applicable to this service fully attained.

The buildings, fittings, furnishings and clinical equipment are maintained to a high standard.

There are sound processes in place for management of clinical and environmental emergencies and security. Evacuation drills are held every six months.

## 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.



Some standards applicable to this service partially attained and of low risk.

The organisation has policies and procedures that support the minimisation of restraint. Two restraints and two enablers were in use at the time of the audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. The use of enablers is voluntary for the safety of residents in response to individual requests. Inservice staff education on restraints, enablers and the management of challenging behaviour is provided.

## 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.

The infection surveillance program has been maintained. The type of surveillance is appropriate to the size and complexity of the service. Infection data is collected, recorded, analysed and reported. Any recommendations to reduce the infection rates are discussed during staff meetings. All staff receive ongoing education on infection control.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	15	0	2	0	0	0
<b>Criteria</b>	0	38	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 documented complaints policy and procedure meet the requirements of Right 10 of the Code. The policy, complaints forms and a drop box are available in the foyer and lounges of the facility. The complaints register sighted was up to date. Actions are taken promptly in response to complaint and are recorded. At the time of audit there were no open internal complaints. A complaint received by the Health &amp; Disability Commissioner in May 2019 relating to an ex patient of the organisation is still being investigated.</p> <p>Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff and management meetings.</p> <p>There was evidence that complaints information is used to identify opportunities to improve services.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was</p>

<p>effective communication.</p>		<p>supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff know how to access interpreter services if required. Contact lists of all interpreters that can be accessed were posted around the two facilities. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.</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 organisation holds contracts with the district health board for age related residential care, long term support for chronic health conditions (LST-CHC) residential non-aged care, respite care and with the Accident Compensation Corporation for rehabilitation. At time of audit there were 26 hospital residents (four of whom were LTS-CHC) plus, 23 rest home residents (four of whom were LTS-CHC) and six ACC residents. Eight residents were under 65 years of age (four rest home care and four hospital care).</p> <p>The owner / general manager is a registered nurse who governs the organisation with input from a chartered accountant, a lawyer and an employment adviser. Strategic planning is undertaken annually by the owner / general manager with input from the members of senior management. The vision, mission, values and goals of the residential service are set by the Board and published in the Residential Information Pack. The 2018-2019 business plan and strategic goals have been updated and reflect organisational planning outcomes. The facility manager, previously a caregiver, is suitably experienced to manage the service and has been in the current role for over seven years. Authority, accountability and responsibility are confirmed in the position description. The manager is a member of aged care associations and maintains ongoing education for management of aged care services.</p> <p>The clinical nurse manager (CNM) is a registered nurse with a current practicing certificate (sighted) who has been in the role operationally for two years and has previous experience as a registered nurse in aged care. The CNM has the overall responsibility for the clinical management of the care facility. The job description outlines the roles, responsibilities, accountabilities and set key performance indicators for the role. The CNM maintains professional development hours for nursing and management. The nurse manager is support by a team of registered nurses for clinical advice and input.</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>	<p>FA</p>	<p>The facility has maintained the documented quality and risk management system and guidelines that support the provision of clinical care. Policies are reviewed by the management team as required. Clinical protocols reflect current good practice and policies meet legislative requirements.</p> <p>Quality and risk performance outcomes are reported and monitored by the organisation's senior management team. A program of internal audits is maintained. Corrective action planning is implemented to manage any areas of concern or deficits. Review of service delivery includes incidents/accidents, infections, complaints and trended data reports from the internal audit programme.</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>PA Low</p>	<p>The adverse event reporting system identifies that staff comply with policy and staff document and report all adverse, unplanned or untoward events. A process to correct deficiencies and prevent recurrence is implemented. Improvement is required to ensure that the neurological status of residents who have an unwitnessed fall is assessed and monitored.</p> <p>The managers are aware of requirements for reporting events to external agencies. Contact details are available.</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>Sound human resources practices have been maintained. Personnel credentials are monitored and were all up to date. There is a scheduled program of staff training, including a documented orientation program for all new staff, and on-going training and competency reviews for current staff. Competency verification requirements are clearly documented. Staff training records confirmed that they are consistently implemented.</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>There is a documented staffing plan. Staffing allocations are appropriate to the layout of the facility. The staffing skill mix is relevant for the level of care and services required. Every shift is covered by at least one registered nurse and three care givers. One or more staff members on each shift have a current first aid certificate. Cover for absence or for increased workloads is provided from part time staff. Bureau staff are not used. Review of resident records and resident and</p>

		family/whānau interviews confirmed that the staffing provided meets residents' needs.
<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>	FA	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe medication management system was observed. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and photos are current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. All medicines are reviewed every three months and as required by the GP.</p> <p>A registered nurse was observed administering medications safely and correctly. The medication and associated documentation are in place. Outcomes of pro re nata (PRN) are documented in the progress notes. Medication reconciliation is conducted by the RNs or CNM when a resident is transferred back to service from hospital. The RN checks medicines against the prescription. Expired or unwanted medicines are returned to the pharmacy in a timely manner. The residents self-administering inhalers were assessed as competent. Administration records were maintained, and medicines kept in a safe place. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted, and this was confirmed on previous entries. Pharmacy service audit was completed on 12 June 2019 and Controlled drug register audit on 14 June 2019 and all corrective action plans were acted upon.</p> <p>Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal are reported and attended to promptly. The service does not keep any vaccines.</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>Meals are prepared on site in each house and served in the respective dining areas. The menu has been reviewed by a registered dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a dietary profile developed on admission which identifies dietary requirements, likes and dislikes, a copy is provided to the kitchen staff. The residents' weight is monitored regularly, and supplements are provided to residents with identified weight loss issues. Residents under the ACC contract have preferred food options</p>

		<p>offered and some are assisted in preparing their own meals.</p> <p>The food service is registered under the new food control plan and verification was on 17 May 2019. The kitchens and pantries were clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained in the electronic management system. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. The residents and family/whanau interviewed indicated satisfaction with the food service.</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 desired outcomes.</p>	FA	<p>All care plans sampled evidenced that interventions are adequate to address the identified needs in the care plans. Reported or identified significant changes are addressed in a timely manner. In interview conducted, the GP confirmed that medical input is sought in a timely manner, that medical orders are followed, and care is always resident centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are 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>	FA	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A residents' social and activities assessment is completed within six weeks of admission in consultation with the family and residents where able. The activities are conducted by the activities coordinator and activities assistant in the hospital and rest home wings. The activities coordinator is responsible for the whole activity programme and provides oversight of the activities assistant.</p> <p>Activities are provided in individual or group settings. Activities are varied and appropriate for residents in the rest home, hospital wing, residents under 65 years. Residents under the ACC contract have specific individual activities developed to meet their goals which are rehabilitation focussed. The latter are assisted where possible with cooking, shopping and performing other household chores.</p> <p>Residents' files have a documented activity plan that reflects their preferred activities and are evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities during the audit. The planned</p>

		<p>activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals, occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GPs and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan. Please refer to the corrective action under 1.2.4.3 regarding assessment and monitoring after a fall.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all 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>	FA	<p>The facility consists of two adjacent houses and 12 self-contained units. All buildings are well maintained internally and externally. Internal areas are well lit; handrails are installed in all bathrooms and in corridors where the level changes. External decks have suitable seating and handrails. The three improvements required following the last audit (1.4.2.4 - to ensure that all stairs have safety barriers to prevent residents from falling down them), (1.4.7.5 – use of a room without a window as a bedroom) and (1.4.8.2 – ranch slider opening onto 60cm drop into a garden) have all been remedied and maintained.</p> <p>All external areas are paved. Suitable external sheltered seating is provided.</p> <p>There is a maintenance program in place that is monitored by the manager. A current building warrant of fitness was sighted that expires on 13-October-2020.</p> <p>An equipment register is maintained by the manager and records confirm that the required functional and calibration checks are up to date. All electrical appliances and equipment are tested and tagged annually by a registered electrician. Current</p>

		registration was sighted for the electrician.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are guidelines provided for management of clinical and other emergencies. There is an approved fire evacuation plan. There has been one minor change to the rest home to take the windowless bedroom out of service that has not affected the plan. Trial evacuations are held twice a year. Records are maintained and evidence that all staff have attended in the last 12 months. There is evidence that any deficits are addressed, and the evacuation retested.</p> <p>The staff training plan includes response to medical emergencies. The majority of staff have a current first aid certificate. All rooms have call bells including the stand-alone units. There are emergency support equipment and supplies appropriate to the level of care provided. Staff report that advice and assistance is readily available after hours.</p> <p>There is a lock down procedure at the end of each day. Staff go in pairs between the buildings at night.</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>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. Infection incident report summary and yearly tracking of infections is done to check for trends. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p> <p>There was evidence that an outbreak of gastric enteritis had been swiftly identified, appropriately addressed and contained, documented and cleared. Required notifications had been made to staff, residents, families, and the district health board.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</p>	PA Low	Tui House has a commitment to providing quality services for residents in a safe environment and work to minimise the use of restraint. All staff receive education

actively minimised.		regarding restraint minimisation and management of challenging behaviours. Interviewed staff understood the difference between a restraint and an enabler. The assessment, approval, monitoring and review process is the same for both restraints and enablers. A restraint register was sighted. An improvement was required to ensure restraint minimisation policy includes types of restraints and enablers used by the organisation.
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## 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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	The documented process for management of falls states that residents who have an unwitnessed fall must have their neurological status assessed and monitored.	Falls records in the files of three of six residents who had had an unwitnessed fall did not evidence any assessment or monitoring of their neurological status as required by the documented falls management policy.	<p>Ensure that all residents who have an unwitnessed fall have their neurological status assessed and monitored.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	Two restraints and two enablers were in use at the time of the audit for safety and comfort. Enablers are used on a voluntary basis and include lap belts, high low beds and bed rails. Restraint minimisation policy was in place however it did not specify types of restraints or enablers used by the organisation.	Restraint minimisation policy did not meet required legislation guidelines.	Restraint minimisation policy was updated on the day of the audit to include the types of restraints and enablers used by the organisation hence no further action is required.

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

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.