

Senior Care Investment Limited - Fraser 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 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:	Senior Care Investments Limited	
Premises audited:	Fraser Manor Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 9 December 2020	End date: 9 December 2020
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:	35	

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
Yellow	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
Red	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

Senior Care Investment Limited - Fraser Manor Rest Home provides care for up to 40 residents requiring rest home level care.

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

There is a new registered nurse that works on site four days a week. Three members of the management team are unchanged from the previous audit.

Four areas identified as requiring improvement at the last certification audit or provisional audit have been addressed related to complaints management, staffing, installing heating in residents' bedrooms in Bellbird Suite A, and the walkway between Bellbird Suites and the main rest home area. Medicine management remains an area requiring improvement. In addition, one new area for improvement is identified related to the timeliness of interRAI assessments and care planning.

Residents and family members interviewed were satisfied with the managers, staff, and the services provided.

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. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Complaints are managed efficiently and effectively.

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 business plan includes the scope, direction, goals, and vision of the organisation. The facility manager works full time at the facility and is responsible for the day-to-day management with the assistance of a registered nurse. The facility manager and the other two members of the management team work together to ensure service planning covers business strategies for all aspects of service.

Quality and risk management systems included having current policies and procedures available for staff, an internal audit programme, complaints management, incident/accident reporting, hazard management, restraint minimisation, and enabler and infection control data collection. Quality and risk management activities and results are shared with managers and staff as appropriate.

New staff have an orientation appropriate for their role. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Staffing requirements are documented in policy. Care staff are allocated designated areas to work each shift. Unplanned staff absences are covered. Residents and family members confirmed during interview that their needs and wants were met.

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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The Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Initial assessments and care plans are developed. There are processes in place to communicate changing care needs of residents to staff. The Fraser Manor Rest Home clinical care team includes the general practitioner, registered nurse, health care assistants and activities staff, with resident and family input.

Activities plans are completed by the activities coordinator in consultation with the registered nurse (RN) and facility manager (FM). Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for. A food control plan was in place.

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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Fraser Manor Rest Home has a current building warrant of fitness. There have been no significant changes to the building since the last audit except for ongoing maintenance. There have been no changes to the approved fire evacuation plan. Heaters have been installed in the bedrooms in Bellbird Suite A. There is not a covered walkway between Bellbird Suites and the main rest home. However, there are appropriate processes in place to mitigate risk for residents.

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 restraint minimisation and safe use policy and associated procedures includes definitions that comply with the standard. There were no residents with restraints or enablers in use at the time of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a documented infection surveillance programme which is appropriate to the size and scope of the service.

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	2	0	0
Criteria	0	39	0	0	2	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>Fraser Manor Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code of Health and Disability Services Consumers' Rights (the Code). During interview, residents, family members, the managers and staff reported their understanding of the complaints process, and this aligns with the facility's policy. Template compliment and complaint forms are available at the main entrance so residents and family members can provide feedback or make a complaint.</p> <p>A complaints register is maintained by the facility manager (FM) who is responsible for the complaint management processes. Five complaints have been received in 2020. These complaints were acknowledged, investigated, and responded to appropriately in a timely manner. There have been no complaints from the Ministry of Health, District Health Board or Health and Disability Commissioner since the last audit. Staff interviewed confirmed they would bring any resident or family member's concerns to the attention of the facility manager, or another member of the management team. The shortfall identified at the last certification audit has been addressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</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 supported in residents' records reviewed. There was one incident where a family reported that there was a delay in being notified but this was later resolved amicably (Refer 1.2.4.3). Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health and medical</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>information is collected to facilitate the effective care of residents.</p> <p>Staff knew how to access interpreter services if required. Staff can also provide interpretation as and when 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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction, and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. The facility manager (FM) works full time at the facility and is responsible for ensuring the day-to-day care needs of the residents are being met, monitoring services and operational issues daily. The chief executive officer (CEO) monitors financial performance, information technology systems and is also responsible for marketing. The CEO works on site some days and remotely some days.</p> <p>The service has a management team consisting of the FM, CEO, and the facility services manager. The facility services manager is responsible for maintaining the facility / environment. The FM and CEO have been in their roles since they purchased the rest home. They are appropriately experienced. The facility manager has previously worked in management roles in other aged care services and the CEO has other business management experience. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at management and clinical related education, forums, conferences, and networking. The FM has completed at least eight hours of education in the last 12 months in accordance with the providers contracts with the Bay of Plenty District Health Board (BOPDHB).</p> <p>There have been changes in the RNs employed since the last audit. Most recently, a new registered nurse was employed two weeks prior to the audit. The registered nurse is experienced in aged residential care services, has current interRAI competency, holds a current annual practising certificate and works on site four days a week. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Another RN has also been recruited and is scheduled to commence employment on 14 December 2020 (see 1.2.8).</p> <p>The service holds contracts with the Bay of Plenty District Health Board (BOPDHB) for rest home level care. Thirty-five residents were receiving services under the Age-Related Residential Care (ARRC) contract at the time of audit, including two residents receiving respite care. Four residents are living in two units in the Bellbird Suites. The FM advised the resident admission agreement does not include a guarantee that the residents will stay in Bellbird Suite permanently. Rather, the resident would be relocated to the main rest home if clinically required for the resident's ongoing long-term care. Short episodes of unwellness are being managed by the RNs and senior health care assistants (HCA's) with the resident staying in Bellbird Suite.</p> <p>A resident currently living in Bellbird Suite, and a family member confirmed being satisfied with the services offered by staff and confirmed their needs are being met. The healthcare assistants (HCAs) interviewed confirmed that HCAs are required to alert the RN or charge nurse if there was any change in any of the residents' conditions.</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>Fraser Manor Rest Home has a quality and risk management system which is understood and implemented by service providers. This includes internal audits/reviews, incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, and compliments and concerns/complaints management. The results of quality and risk activities are communicated to the management team. Corrective actions are taken when improvements are identified. For one resident the actions taken in response to falls and episodes of challenging behaviour were not sufficiently detailed to guide staff practice. This is included in the area for improvement in 1.3.3.3.</p> <p>Quality information is also shared with staff via shift handover as well as via the monthly staff meetings that occurred depending on the Covid alert level at the time. The minutes of three staff meetings sighted were sufficiently detailed and made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations, policies/procedures, incidents/accidents, restraint minimisation, staff education/training, the results of internal audits, and facility/general business activities.</p> <p>The senior leadership team, comprising the facility manager, facility services manager, the RN, the facilities/administrator, and the activities coordinator, normally meet weekly. Minutes of three recent meetings included discussion on quality and risk issues, human resources, facilities, and individual resident care needs.</p> <p>A resident satisfaction survey was scheduled to occur in 2020, however has been deferred to January 2021 due to the impact of Covid-19.</p> <p>Policies and procedures are available to guide staff practice. These have been developed by an external consultant and reviewed by the FM to ensure the content reflects Fraser Manor Rest Home requirements. Policies and procedures were updated in November 2020 to reflect the requirements of the Privacy Act (December 2020). The management team have access to the electronic copy of the policies and procedures. A printed copy of these documents is available for staff reference. The FM is responsible for document control procedures. Staff interviewed confirmed they can access required policies easily and were informed when policy document content has been updated. All requested policies and procedures were sighted during audit and all had been reviewed in the last two years.</p> <p>Actual and potential hazards are identified in the hazard register. This was dated as reviewed in November 2020. There is a process in place for staff to report new hazards when identified. A register is also maintained of the chemicals held on site and the locations.</p> <p>The facility manager described the organisation's risks and ongoing mitigation strategies. Risks are detailed in the business, quality and risk management policy and are reviewed regularly. The front entrance is currently secure. Persons entering must ring the call bell and staff review and grant access. The management team advise this is not to stop access but to ensure staff can undertake the appropriate Covid-19 related safety screening and ensure</p>

		the details of everyone entering the facility is documented.
<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>	FA	<p>Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.</p> <p>Applicable residents' accidents and incidents have been reported in a timely manner. Sampled events had been disclosed with the resident and/or designated next of kin as was appropriate. This was verified by residents and family members interviewed with one exception noted. A family member noted a delay in staff communicating about a resident's bruises. This was subsequently resolved amicably. Records of communications were maintained in the sampled residents' files including on the incident report which is filed in the residents' records once addressed.</p> <p>Staff are completing paper-based incident reports. Since January 2020, these events have been logged onto an electronic register. A review of reported events, including witnessed and unwitnessed falls, challenging behaviour, a skin tear, medicine error, and bruising, demonstrated that incident reports were completed, investigated, and responded to.</p> <p>A newer resident has had a number of reported incidents including falls and challenging behaviour. The resident was admitted for short term care, that progressed to long term care; however, they had not had an interRAI assessment completed or initial long-term care plan developed within the aged related residential care contract times required. There is insufficient guidance in this resident's initial care plan for staff related to the resident's changing fall prevention and behaviour needs. This is included in the area for improvement raised in criterion 1.3.3.3. Despite this, staff interviewed confirmed the changing requirements had been communicated to them verbally. This resident has been reviewed by the general practitioner and a number of strategies attempted and evaluated in response to the reported falls and behaviours.</p> <p>A falls prevention committee meeting occurred in October 2020 to discuss strategies due to an increase in the number of resident falls. Medicine related processes have also been reviewed in response to an increase in medication related errors/events or omissions.</p> <p>The facility manager advised there has been three essential notifications to the Ministry of Health and/or District Health Board since the last audit. These related to a missing resident, a flooding event, and a trespasser being outside in the grounds at night (not inside the buildings). The facility manager can detail the type of events that require reporting. There have been no events that required reporting to the Coroner.</p>
Standard 1.2.7: Human	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process included completing an application form, interview, and referee checks. Police

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>vetting is occurring as staff are employed. A job description and employment contract were present in sampled files and privacy/confidentiality statement. A sample of staff records reviewed confirmed that policies are being consistently implemented and records retained.</p> <p>All employed and contracted registered health professionals (RHPs) have a current annual practising certificate (APC). Copies of the APCs are on file.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared new staff for their role and responsibilities. Staff records reviewed showed documentation of completed orientation or orientation is still ongoing.</p> <p>A staff education programme is in place with in-service education planned and several opportunities/topics planned each month. Education was primarily focused on infection prevention and control, hand hygiene, use of personal protective equipment and Covid-19 in 2020 with some other planned education topics deferred. The general education programme has recommenced once it was deemed safe to do so. The planned education topics align with these standards and the facility's contract with BOPDHB. Records of education attendance are maintained.</p> <p>There are 17 HCAs employed. Care staff are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two care staff have completed level two, three staff have completed level three and one staff member has completed level four of an industry approved qualification. One HCA is currently completing level three and one is completing level four of an industry approved qualification. Two staff have completed the New Zealand certificate in Cleaning (Level two).</p> <p>A performance appraisal is required to be completed within three months of employment, and annual performance appraisal is required for staff thereafter. The FM monitors when these are due.</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 facility adjusts staffing levels to meet the changing needs of residents. This was observed during audit when a new resident admitted to the Bellbird Suite for short term respite care was noted by staff to be confused and disorientated. A staff member (additional to rostered HCA's), provided one on one supervision for safety as the residents' needs were noted to be changing.</p> <p>The FM works Monday to Friday and is on call when not on site. The CEO works on site or remotely as required. The facility services manager is responsible for facility and maintenance and is on-site weekdays 9 am to 5 pm.</p> <p>An RN is rostered on duty Monday to Thursday morning shifts. She has a post graduate diploma in infection prevention and control (Waiariki Institute of Technology - 2011) and interRAI competency.</p> <p>Another RN with interRAI competency has been recruited for a full-time role starting Monday 14 December 2020. The management team advise becoming aware that interRAI assessments were not being conducted in the timeframes required by the ARCC timeframes and were working to address this. With the recent resignation of the</p>

	<p>previous full time RN, the decision was made to recruit two interRAI competent RNs. The newly employed registered nurse was interviewed and confirmed being aware that there are resident interRAI assessments and care plans overdue and has started to prioritise the residents to be completed first. The overdue interRAI assessments and long-term care plans are raised as an area for improvement in criterion 1.3.3.3.</p> <p>Caregivers are required to inform the RN of any changes in residents' condition. The RN provides oversight of clinical care for all residents.</p> <p>Designated caregivers on duty in the main rest home area provide care to and oversight of the residents in Bellbird Suite on morning and afternoon shifts. This includes regularly checking on the residents throughout the day and evening. The RN office area is also located in Bellbird Suite. At night, an HCA is rostered and based in Bellbird Suites and is responsible for checking each resident regularly throughout the night. The staffing arrangements for Bellbird Suite were subsequently discussed with the DHB portfolio manager by phone and accepted as suitable. The resident interviewed in Bellbird Suite and a family member confirmed that staff are designated to provide their care and undertake regular routine checks of their wellbeing throughout the day, afternoon, and night. A resident noted that a staff member is based in their Bellbird Suite at night.</p> <p>A senior HCA is rostered on duty at least five days a week and is currently working the morning shifts when the RN is not on duty. In addition to the RN or senior HCA, there are four caregivers on duty in the morning working a variety of hours. There are three HCAs in the afternoon and at night.</p> <p>Activities are provided weekdays 9.30 am to 4.00 pm. A chef is on site daily from 7 am to 3.30 pm and a cook on duty daily 1.45 pm to 6.30 pm. A kitchen hand is rostered 7 am to 9 am and 4.15 pm to 6.15 pm daily. There are designated staffing hours allocated daily for cleaning and laundry services.</p> <p>Current vacancies include a weekend chef/cook, and a cleaner. This is a short-term cleaning position to cover the Christmas holiday period.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. The afterhours on call service is provided by the current RN Monday to Thursday and another registered nurse Friday to Sunday. The RN on call Friday to Sunday has previously worked in the rest home and is familiar with the staff, facility, routine and many of the residents. Care staff interviewed confirmed access to clinical advice after hours and confirmed there were sufficient staff available to complete the work allocated to them, and additional support is provided when required.</p> <p>Observations and review of a current-week roster cycle confirmed adequate staff cover has been provided, with unplanned absences replaced. Where applicable, if there are no employed staff available to cover the shift an agency contractor is utilised. An agency staff member was working on the day of audit and was observed to be given an orientation to the facility, individual residents, and processes/routine. The FM advises agency staff are infrequently used and this was verified in a review of the agency utilisation data.</p> <p>Sixteen staff have a current first aid certificate. There is at least one staff member on duty who has a current first</p>
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		<p>aid certificate. The shortfall identified at the provisional audit has been addressed. There is a staff member on duty each shift with a current medicine competency.</p> <p>The residents and family members interviewed confirmed that care is provided to meet the residents' needs.</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>PA Moderate</p>	<p>The medicine management policies and procedures clearly outline the service provider's responsibilities in relation to all stages of medicine management. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurse when the resident is transferred back to the service from hospital or any external appointments. Medication competencies were completed annually for all staff administering medication. Staff are required to report medicine errors or omissions via the incident reporting system. Applicable events are being reported. There has been a recent meeting with staff in response to medicine errors and omissions and some changes in practice implemented.</p> <p>There were two residents self-administering medicines at the time of the audit and they had been assessed as competent to do so. Their medicines were stored in a safe and secure place. Administration records are maintained. A self-administration medication policy and procedure was in place.</p> <p>Outcomes of pro re nata (PRN) medicines administered were not documented consistently and controlled drugs (CD) weekly stock takes were not occurring. The area identified as requiring improvement at the last certification audit remains open.</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>There is an approved food plan for the service. The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Residents are provided with alternative meals when needed and are encouraged to complete a meal request form. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. There is a six-weekly rotating winter and summer menu in place. Meal services are prepared on site and served in the allocated dining rooms. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required.</p> <p>The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was registered under the food control plan and the registration expires 16 March 2021. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning is conducted.</p>

		Five staff have completed external food safety training.
<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>Documented Interventions in the service delivery plans were relevant to address the assessed needs and desired goals/outcomes. The exceptions are noted in 1.3.3.3. All significant changes were reported in a timely manner and prescribed orders carried out. The GP reported that medical input was sought in a timely manner that medical orders were followed, and care is person centred. The GP is available for cover on a 24-hour basis and if on leave cover is arranged. Care staff confirmed that care was provided as outlined in the care plan or handover processes.</p> <p>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 meaningful to the residents' needs and abilities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and areas of enjoyment. Reviewed residents' files reflected their preferred activities and were evaluated regularly or as and when necessary. The activities coordinator develops a monthly activity planner which covers activities for all residents. These are posted on the notice boards or given to residents. Activities are either conducted in group sessions or one on one. Residents' activities information was completed in consultation with the family during the admission process.</p> <p>The residents were observed to be participating in a variety of activities on the day of the audit. There are planned activities and community connections that are suitable for the residents. There are regular outings for all residents at least twice a month.</p> <p>Residents and family/whanau 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 RN reads progress notes weekly, documents as necessary and countersigns in the process. All noted changes by the health care assistants are reported to the RN in a timely manner. Care staff are supported and guided in the treatment and management of residents.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, has not occurred every six months or as residents' needs change. (Refer to the area for improvement raised in 1.3.3.3). Evaluations are carried out by the RN in conjunction with family, GP, and specialist service providers. Where progress is different from expected, the service responds by initiating changes</p>

		<p>to the services provided.</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>There was a current building warrant of fitness (BWOFF) with an expiry 23 June 2021. There have not been any changes to the facility since the last audit except for ongoing maintenance. There have been no changes required to the fire evacuation plan that was approved by the New Zealand Fire Service prior to the last certification and provisional audits.</p> <p>The walkway between the Bellbird Suites and the main rest home is uncovered. This was identified as an area for improvement at the provisional audit when a covered walkway was identified as being required. The facility manager advised this was investigated and was not progressed due to the height required to safely allow an ambulance to drive through this area when required. Care staff and managers interviewed advised staff walk with residents between these buildings and this was observed during audit. Umbrellas are available if required. In the event of wet weather, or at any other time requested by residents, staff take meals out to the residents in the Bellbird Suites. A resident living in Bellbird Suite and a family member interviewed were very satisfied with the arrangements in place. These arrangements were subsequently discussed with the DHB portfolio manager and accepted. The shortfall from the provisional audit has been addressed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility is well ventilated and heating is available. Wall mounted heaters have been installed in the two units in Bellbird Suites Unit A. The shortfall from the provisional audit has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has</p>

<p>infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>an infection and appropriate antibiotics are prescribed for all diagnosed infections. Infection control surveillance data confirmed comparative information with previous months.</p> <p>There were no infection outbreaks reported since the last audit. Information and resources to support staff in managing Covid-19 was regularly updated. Visitor screening and residents' temperature monitoring records, depending on alert levels as advised by the Ministry of Health, were documented.</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>Policies and procedures guide staff practices related to restraint minimisation and safe practice and the use of enablers. Staff are provided with training on these topics during orientation, and it is included in the mandatory staff education programme. The topic was scheduled for earlier in 2020, however was deferred due to changes in the education focus and processes because of the Covid-19 pandemic and restrictions in place due to the national alert level at the time. This topic has been rescheduled for 2021.</p> <p>There were no residents using restraints or enablers at audit. Staff interviewed demonstrated understanding of the differences between restraints and enablers.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>The GP reviews medication every three months and as required. Pro re nata (PRN) medicines are being administered. Evaluations of the effectiveness of PRN medicines are inconsistently documented. Allergies were clearly indicated, and photos current for easy identification. All expired medications were returned to the pharmacy in a timely manner. The senior health care assistant (HCA) was observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug (CD) register was in place. Six-monthly stock take of controlled drugs is occurring. However, weekly stock takes were not occurring though were sighted to be occurring in late 2019.</p> <p>Monitoring of medicine fridge temperatures are conducted regularly and deviations from normal were reported and attended to promptly. The service does not store any vaccines on site.</p>	<p>The outcomes/effectiveness of pro re nata (PRN) medications is not consistently evaluated and documented.</p> <p>Weekly checks of the controlled drug register balances are not being completed.</p>	<p>Provide documented evidence that the balance of controlled drugs is being checked and documented weekly.</p> <p>Ensure the effectiveness of pro re nata medicines administered is being evaluated</p>

				consistently. 90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Initial admission assessments and initial care plans are completed, and these were sighted in all residents' files sampled. Residents' care plans were completed within three weeks of admission along with interRAI assessments, with one exception noted. A resident admitted for short term care which extended to long term care does not have an interRAI assessment and long-term care plan completed within ARCC contract timeframes. This resident has had falls and episodes of challenging behaviour. Interventions to address these issues are not sufficiently documented in the resident's records. Despite this care staff were aware of the interventions required to help support this resident, as these had been communicated to staff verbally.</p> <p>Six monthly, interRAI assessments were not updated in a timely manner resulting in long-term care plans not being reviewed within contractual requirements. Assessments and care plans are completed by a RN, with the GP and activities coordinator and care staff involved in the review process. This was confirmed by family/whanau in interviews. Evidence of this was sighted in seven residents' files reviewed.</p> <p>Completed short term care plans were evidenced when there was a change in condition including (but not limited to): skin conditions, behaviour management, chest infections and wound infections.</p>	<p>InterRAI assessment and review of resident's long term care plans have not occurred within timeframes required by the ARCC contract for five out of seven applicable residents whose files were sampled.</p> <p>One other resident did not have an initial interRAI assessment and initial long term care plan completed as required by the ARCC contract. This resident has had falls and episodes of challenging behaviour. The care plan available to staff does not provide sufficient guidance on these aspects of care.</p>	<p>Provide evidence that interRAI assessments and sufficiently detailed long-term care plans are completed and reviewed in required timeframes as detailed in the ARCC Contract.</p> <p>90 days</p>

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.