# Logan Samuel Limited - Anne Maree Court

## Introduction

This report records the results of a Certification 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Logan Samuel Limited

**Premises audited:** Anne Maree Court

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

**Dates of audit:** Start date: 7 April 2021 End date: 8 April 2021

**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:** 46

# 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 |
|  | 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

Anne Maree Court provides rest home and hospital level care services for up to 57 residents.

This recertification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of organisational documentation, staff files and residents’ clinical files, observations, and interviews with residents, families/whānau, staff and the general practitioner (GP).

The most significant change since the surveillance audit in October 2019 is the appointment of a new facility manager and a change of clinical leader. There have been no major changes to the physical environment or scope of services provided.

Feedback from residents and families/whānau members was positive about the care and services provided.

This audit resulted in one improvement required. This was related to evaluating the effects of ‘as required’(PRN) medicines.

## Consumer rights

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| --- | --- | --- |
| 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. |

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code), and these are respected. The services provided support personal privacy, independence, individuality, and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. 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.

There is a Maori health plan to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

Review of complaint records and interviews with staff, demonstrated that complaints received since the previous audit has been managed effectively. The residents and families interviewed confirmed that information on the complaints process has been provided to them and that they understand how to raise concerns/complaints.

## 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. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Regular monitoring of all service areas is occurring. Staff are involved and feedback is sought from residents and families. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

Adverse events are reliably reported by all levels of staff. There is evidence that people impacted by an adverse event are notified, for example, general practitioners, residents and families. Notification of serious events is occurring as required by regulatory requirements.

The appointment, orientation and management of staff is based on good employment practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

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

Access to Anne Maree Court is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurses and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified 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. |

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite/offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

The restraint systems and practices meet the requirements of this standard. There were no residents using restraint or enablers on the days of audit. Assessment, consent, approval and monitoring and review processes are known by staff if interventions are required. Staff training on restraint and enabler use is being provided regularly.

## Infection prevention and control

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| --- | --- | --- |
| 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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent, and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There has been no infection outbreak reported since the last audit.

## 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 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Anne Maree Court has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). The interviewed staff understood the requirements of the Code and were observed communicating with residents in a respectful manner, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records sighted. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The informed consent is included in the admission agreement. Signed admission agreements were sighted in the clinical files reviewed. Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff.  Clinical files reviewed show that advance directives for resuscitation have been gained appropriately using the organisation’s standard form. Enduring power of attorney (EPOA) requirements and processes for residents who are unable to consent is defined and documented. Activated EPOA documents were sighted where appropriate. Staff were observed to gain consent for daily care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.  The service is maintaining a complaints register and effectively managing the complaints process. Residents and family members interviewed demonstrated knowledge and understanding about how to raise a complaint. Interview with the owner and the facility manager and review of the documentation related to the complaints logged in 2020 to 2021 confirmed that each matter was investigated immediately and managed effectively for resolution with all parties. There was evidence of ongoing communication with all people involved and external advocacy had been offered where necessary.  There have been no complaints investigated by the Office of the Health and Disability Commissioner (HDC) or the DHB since the 2019 surveillance audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The interviewed residents and family were aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service). They reported that these were discussed with staff on admission and was part of the admission information provided. The Code is displayed at the reception area together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Residents’ personal belongings and property are recorded on admission and are labelled for easy identification. The residents reported that they receive back their clothes after laundering in a timely manner. Staff maintained privacy when providing care throughout the audit. All residents have a private room.  Residents are supported to attend to community activities and to participate in clubs of their choosing to maintain their independence. The care plans included documentation related to the residents’ abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.  Interviewed staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. The interviewed GP and families have not witnessed or observed any abuse nor neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Residents who identify as Māori are supported to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents who identify as Māori and their whānau reported that staff acknowledge and respect their individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents’ individual culture, values and beliefs are assessed on admission. The interviewed residents confirmed that they were consulted on their needs and that staff respected these. Residents’ personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents, family members and the general practitioner (GP) interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. These are included in the employee handbook and are discussed with all staff during orientation period. The registered nurses have completed training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice team, diabetes nurse specialist, wound care specialist, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education, online education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included regular internal audits with corrective actions implemented as required. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  The clinical leader (CL) reported that access to interpreter services is through the local hospital board. Staff knew how to access interpreter services, although reported this was rarely required due to most residents able to speak English. Staff can provide interpretation as and when needed, or family members and communication cards are used for those with communication difficulties or for whom English is a second language. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of weekly reports from the facility manager to the owners contained sufficient information to monitor performance. Information reported includes occupancy, incidents, staffing and any emerging risks and issues.  The service is managed by a facility manager (FM) who is supported on site by a full-time clinical leader. Both are RNs with previous experience in aged care. The FM commenced the role in January 2021 as did the clinical leader who was already employed at Anne Maree Court as a senior RN. Notifications about these staff changes had been made to the DHB and Ministry of Health (MoH). The clinical leader and manager maintain currency with their roles by attending ongoing professional development and through regular meetings with the DHB and their peers.  Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. The FM has 17 years’ experience working as a manager in the aged care sector, and fully understands the regulatory and reporting requirements.  Anne Maree Court has agreements with the DHB for age related care (ARCC) in rest home, hospital (medical and geriatric care), palliative care, respite/short stay and day services and Long-Term Services, Chronic Health Care (LTS-CHC) and an agreement with MoH for Young people with Disabilities.  On the first day of audit 46 of the 57 beds were occupied. A natural, expected death and two admissions occurred during the audit. Twenty-seven residents were receiving rest home level care, including two respite. Nineteen residents were receiving hospital level care, which included one respite resident. Two residents were under 65 years of age, one was funded under mental health and the other under LTS-CHC. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | When the facility manager is absent, the owner and the general manager (in the process of returning from maternity leave) are on site daily to carry out all the required duties. Another senior RN steps up to cover the clinical leader’s absence. This is always allocated to an RN who is experienced and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, reporting and tracking of infections and restraint events, scheduled internal audits, regular resident and relative satisfaction surveys and monitoring of outcomes.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at a variety of management team, quality and health and safety team meetings, RN and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and feedback from quality analysis. Graphs showing the prevalence of falls and when these occur are displayed in the staff room. Where necessary corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Feedback from family and residents was positive. Where surveys raise areas of concern, these are investigated, and action is taken to address any improvement required.  The policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  Management and the owners understand the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Staff and the managers are familiar with the Health and Safety at Work Act (2015). Health and safety coordinators are trained and vigilant in reporting, recording and mitigating risks from hazards. The hazard and risk control register is kept up to date and reviewed monthly. There have been no reports to Worksafe NZ in this audit period. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed for 2020-2021 revealed clear descriptions of the event and evidence of notifications to people impacted by the incidents, for example, family, the manager on call and/or the GP. All incidents were being reviewed and investigated by the FM, and the clinical leader to determine cause and effect and what if any type of actions require follow-up. There was evidence that actions are monitored for implementation. Consequential actions are recorded in the resident’s electronic progress notes. Adverse event data is collated, analysed and reported to staff as described in standard 1.2.3.  The owners and the FM understand and adhere to the requirements for essential notification reporting. The records showed appropriate notifications of significant events made to the Ministry of Health and DHB. There have been no coroner’s inquests, police investigations or issues-based audits. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Staffing policies and practices are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The new FM confirmed their recruitment, and appointment process as conforming to good employment practice. A sample of seven staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation followed by an initial performance review.  Continuing education is planned on an annual basis, including mandatory training such as emergency processes, medicine competency and first aid for those staff who required these. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. Records reviewed demonstrated that nine of the 23 caregivers have completed level 4 or higher of the National Certificate in Health and Wellbeing (or its equivalent). Four carers have achieved level 3, one has achieved level 2 and the remaining nine are in progress to achieve levels one and two. Three of the six RNs employed are maintaining annual competency requirements to undertake interRAI assessments. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are adjusted to meet the changing needs of residents.  The care staff interviewed reported there were typically enough staff available to complete the work allocated to them. Residents and family interviewed supported this.  Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence through call backs and a reliable pool of casual staff. While the bed numbers are not at full capacity, the number of staff typically rostered on is four carers in the morning (three from 7am to 3pm and one from 7am to 2pm) plus two RNs and the FM during Monday to Friday. Three carers are allocated for afternoon shifts (two from 3pm to 11pm and one from 3pm to 9pm) plus one RN and there are three carers and one RN on site during the night. Staff said that carer numbers were the same on the weekend but the number of RNs was reduced from two on the floor to one RN per eight hour shift and there was no FM. They said the afterhours on call roster provided good access to RN advice when needed.  At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) RN coverage in the facility. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | An electronic information management system is in use for most residents’ information except for the admission agreements, consent forms and admission information that are paper based. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Staff have individual passwords to access the electronic system.  Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The facility manager is responsible for managing the admission enquiries. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. NASC documents with appropriate levels of care were sighted in the sampled files. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Anne Maree Court’s facility brochure and website have adequate information on the services provided by the facility.  Family members and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed that adequate information was shared for ongoing of care of the resident. Family of the resident reported being kept well informed during the transfer of their relative. The CL stated that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | The medication management policy was current and identified all aspects of medicine management in line with the legislative requirements. A safe system for medicine management using an electronic system was observed on the days of audit. The HCA and RN observed administering medicines 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 have current medication administration competency.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs complete medication reconciliation when the packs are received from the pharmacy and when residents return to the facility post external appointments. Regular medicines and bulk supply medicines were stored safely in the locked medication room and the medicine trolley. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  There were three residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. Current self-administration of medication competency forms were sighted.  There is an implemented process for comprehensive analysis of medication errors and corrective actions implemented as required. Regular medication audits were completed with corrective action plans implemented.  Administered pro re nata (PRN) medicines were not consistently evaluated for effectiveness. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a qualified chef and is in line with recognised nutritional guidelines for older people. There is a four-weekly rotating cycle menu which was last reviewed by a registered dietitian in February 2021.  Residents’ nutritional assessments are conducted 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 residents’ nutritional needs, was available. Residents’ weights are monitored regularly, and any identified concerns were managed appropriately.  The interviewed residents expressed satisfaction with meals and this was verified in satisfaction surveys and resident meeting minutes. The observed meal services confirmed that residents were given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.  All aspects of food procurement, storage and preparation met requirements. Kitchen staff have received the required food safety qualifications. Temperature checks of fridges, freezers and cooked food are maintained. There is a current food control plan issued by Ministry of Primary Industries (MPI). A current food control plan verification report was sighted. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The facility manager reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Nursing assessments are completed on admission using the organisation’s assessment tools, such as, a pain scale, falls risk, skin integrity, nutritional screening and continence assessments, as a means to identify any deficits and to inform care planning within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and six-monthly. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Changes in care required was documented and verbally passed on to relevant staff. Residents and families confirmed participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation in care plans reviewed, observations and interviews verified that 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. The interviewed GP confirmed that medical input is sought in a timely manner, that medical orders are followed, and care provided meets the needs of residents. Care staff confirmed that care was provided as outlined in the care plans. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  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. | FA | The activities programme is provided by a trained diversional therapist (DT) holding the national Certificate in Diversional Therapy, and an activities coordinator who is in the process of completing DT training.  Social assessments and history are undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. The DT is responsible for completing the activities care plans for all residents. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated when there is a significant change in participation and as part of the formal six-monthly care plan review.  Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents were observed participating in a variety of activities on the days of the audit. Activities on the programme included weekly church services, quiz, newspaper reading, exercises, walks, music, external entertainment, movies, birthday celebrations and outings. Residents who are under 65 years attends to activities of choice and are supported to attend to activities outside the facility as required. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. The interviewed residents confirmed that they find the programme satisfactory. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes in the electronic system by the healthcare assistants (HCAs) in each shift and daily by the RNs. The HCAs reported that any changes noted are reported to the RN. This was confirmed in the handover observed and in residents’ records reviewed.  Formal care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents’ needs change. Where progress was different from expected, the service responded by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for urinary tract infections, wounds, and weight issues. Residents and families/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or CL sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the hospice team, oncology and speech language therapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented procedures for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.  There was ample provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness with an expiry date of 30 November 2021 is publicly displayed in the entry foyer.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Daily checks occur to ensure the environment is hazard free, that residents are safe and independence is promoted.  External areas are safely maintained and are appropriate to the resident group and setting.  Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. Records sighted and staff interviewed confirmed that all requests are promptly actioned. Staff, residents and their family members said they were happy with the environment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient numbers of accessible bathroom and toilet facilities throughout the facility. This includes 31 rooms with toilet/shower ensuite, three with no ensuite and twenty-three rooms which share a toilet with another resident. Additional toilets and showers are located in each wing and within easy access to bedrooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. Mobility aids, walkers and wheelchairs are stored safely and out of the way, so as not to impede egress when not in use. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. The main lounge area is spacious and the majority of hospital residents stay there during the day for entertainment and meals. The designated dining room is on the opposite side of the facility which can be easily accessed by mobile residents or by cutting across the inner courtyard. There are two other lounges which are thoroughfares but provide alternate areas for visiting, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken off site by a contracted provider. Family and residents interviewed reported the laundry is managed well and that clothes are returned in a timely manner.  There is a small designated cleaning team who have been employed for many years and are appropriately trained. This was confirmed in interviews with cleaning staff and through review of training records. The cleaning store room is immaculate and orderly. Chemicals were stored in a safe and secure manner and decanted into appropriately labelled containers.  The effectiveness of cleaning and laundry processes is monitored through the internal audit programme. No deficits or areas to be improved were identified by internal audits or during this on-site audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The fire evacuation plan was approved by the Fire and Emergency New Zealand Service (FENZ) some years ago and is still current as no changes to the structure of the building have occurred since. A trial evacuation takes place six-monthly with a copy sent to FENZ, the most recent being 05 February 2021.  The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted. Water storage tanks are located around the complex and the amount of water stored on site meets the Ministry of Civil Defence and Emergency Management recommendations for the region. There is no generator on site, but hot water and heating can be produced by gas if necessary. Emergency lighting is regularly tested. A large generator was successfully hooked up to the facility in early 2021 to ensure service delivery continued during a planned power outage. Staff stated this arrangement worked well.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no security incidents since the previous audit. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by individual panel heaters in residents’ rooms and corridors and large heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Anne Maree Court has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialists. The infection control programme is reviewed annually. This was last reviewed in January 2021.  The clinical leader is the designated infection control coordinator (ICC), whose role and responsibilities are defined in the infection control coordination policy. Infection control matters, including surveillance results, are reported monthly to the facility manager and quality improvement coordinator, and tabled at the heads of department meeting. This committee includes the facility manager, IPC coordinator, HCA, and representatives from food services and household management.  There is signage at the main entrance to the facility requesting anyone who is or has been unwell with flu like symptoms in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities. A Covid-19 screening questionnaire is completed by all visitors who enter the facility and temperature monitoring is conducted. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has been in this role for two months and has appropriate skills and knowledge for the role. They have attended relevant infection prevention and control education, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The ICC has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on the days of the audit. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed within the past year and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. The interviewed staff demonstrated knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the ICC and online education can be accessed for those who are unable to attend onsite sessions. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance was maintained, and high staff attendance levels were demonstrated. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when during the beginning of the Covid-19 pandemic.  Education with residents is on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hotter weather and appropriate perineal hygiene for urinary tract infections. Infection control issues were discussed with residents in residents’ meetings as verified in the meeting minutes sighted. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, influenza, the upper and lower respiratory tract. The ICC reviews all reported infections, and these were documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Internal audits were completed regularly, and corrective actions implemented as required. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager, and all staff.  No infection outbreaks have been reported since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility.  On the days of audit, there were no residents using restraints or enablers. There are several alternatives to restraint in use to prevent injury to residents. These include sensor mats, low beds and ‘fall out’ mats and the use of infra-red light beams to alert staff to movement in the resident’s bedroom.  The front door has a keypad lock for the safety of wandering and/or confused residents. Competent residents were observed to be using the keypad to exit whenever they wanted, or staff at the front desk assisted them and visitors to open the door. This type of environmental restraint is openly acknowledged by the service and residents and/or their family/EPOA sign consent and agreement for this.  Restraint is used as a last resort when all alternatives have been explored. There have been no restraint interventions for more than four years. This was evident on review of the falls/restraint group minutes, files reviewed, and from interviews with staff. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  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. | PA Low | The prescriber’s signature and dates for the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were documented on the electronic medicine charts sighted. The required three-monthly GP reviews were consistently recorded on the medicine chart. The administered PRN medicines were not consistently evaluated for effectiveness. | Ten out of fourteen sampled medication charts did not have consistent evaluation of the administered PRN medicines. | Provide evidence that administered PRN medicines are evaluated for effectiveness.  90 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.