

Howick Baptist Healthcare Limited

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:

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| Legal entity: | Howick Baptist Healthcare Limited |
| Premises audited: | Howick Baptist Home and Hospital |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 4 May 2021 End date: 5 May 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: | 121 |

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 |
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|  | 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 |
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| 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

Howick Baptist Healthcare Limited (HBH) provides rest home and hospital level care to a maximum capacity of 129 residents.

This planned certification audit was conducted against the Health and Disability Services Standards and the provider's contract(s) with Counties Manukau District Health Board (CMDHB). The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, their family, management, staff and a general practitioner.

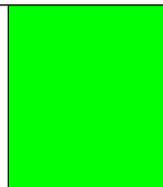
The chief executive officer (CEO) is appropriately qualified for the position and is experienced in working in the sector. The executive management team have changed since the previous audit and all report to the CEO who then reports to the Board of Trustees.

This audit identified one area requiring improvement in relation to self-administration of medicines.

Three ratings of continuous improvement were identified. These are in relation to the business planning and restructuring that has occurred, the quality and risk monitoring programme and continuous quality improvements and the onsite activities programme.

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.

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

A complaints register is maintained with complaints resolved promptly 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.



All standards applicable to this service fully attained with some standards exceeded.

The Trust Board provides effective governance. The board meets monthly and are kept informed about all aspects of the organisation.

The CEO and all other members of the executive team established February this year are appropriately qualified/experienced for their positions and/or are experienced with working in the aged care sector.

There are well established quality and risk management systems which meet the requirements of these standards. The organisation continues to benchmark its quality data against similar age care services. Risk management systems are fully

implemented. All adverse events were being reliably reported and investigated. There have been no notifications to Counties Manukau District Health Board and the Ministry of Health.

Staff are managed well according to policy and good employer practices. New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff. Ongoing staff education is planned and delivered in ways that ensure that staff receive relevant and timely training on subjects related to their roles and service provision to older people. Staff attendance at mandatory education sessions is monitored. The training is available to all staff through in-service teaching sessions, self-directed learning and presentations by external experts. Aspects of staff training have been strengthened. Staff competency assessments and performance appraisals are occurring regularly.

There are enough clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of residents. The allocation of registered nurses (RNs) across the site 24 hours a day seven days a week exceeds contractual requirements. The level of staff retention exceeds other similar organisations.

Continuum of service delivery

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| 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. |
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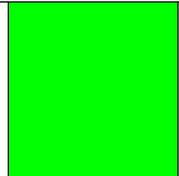
Residents receive services in a competent and timely manner. The registered nurses (RNs) and enrolled nurses (ENs) are responsible for completing nursing assessments, care plans and evaluations. InterRAI assessments are up to date. Interventions were adequate to meet the residents' assessed needs.

The planned activities are appropriate to meet the needs, age, culture, and setting of the service. The activities reflected the ordinary patterns of life and included involvement of other representatives and other community groups.

The service uses a pre-packaged medication system and electronic medication management system. Medication is administered by staff with current medication administration competencies. Medication reviews are completed by the general practitioners (GPs) in a timely manner.

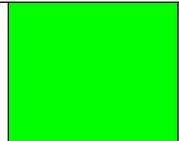
The food services is provided by an external provider. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. There is a current food control plan in place.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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The organisation has a current building warrant of fitness and this is displayed publically. All electrical checks and calibration of equipment is current and up-to-date.

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. |
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The restraint policy and procedures comply with this standard and are written in a way that clearly guide staff. On the days of audit there were thirteen restraint interventions in place and five residents using bedrails as enablers. The need for these had been

appropriately assessed and consent obtained. Staff knowledge about the organisation's approach to restraint and their competence in safe application of restraint interventions is tested at least annually.

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. |
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The infection control surveillance programme is suitable to the size and scope of the service. Infection rates are monitored, and results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 1 | 14 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 3 | 37 | 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](#).

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaint management system complies with right 10 of the Code and the requirements of this standard. The information is provided to residents on admission and there is complaints/compliments information and forms available at reception. A box is provided in which to place the forms.</p> <p>All concerns, complaints or compliments are entered into the electronic system as soon as they are received. Details about the matter and its progress is then accessible to the CEO and authorised senior staff. Significant matters are discussed at monthly senior management meetings and reported to the board. Staff, residents and their family members interviewed demonstrated knowledge and understanding of the complaint process. Families described staff as being open, responsive and keen to address any matters they raised with them.</p> <p>There have been nine minor complaints received since the previous audit, one DHB complaint which has been resolved and one Coroners case which remains open.</p> <p>The CEO is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding for the complaint process and what actions are required.</p> |
| Standard 1.1.9: Communication | FA | Residents and family members stated they were kept well informed about any changes to 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 supported in residents' records reviewed. Staff interviewed understood the principles of open |

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| <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>disclosure which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff understood how to access interpreter services when required through the DHB.</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>Howick Baptist Healthcare have agreements with CMDHB to provide age residential care for hospital geriatric and rest home services, respite/short term care, services to people with long term support chronic health conditions and a day activities programme. There are also contracts with the MoH and the local Needs Assessment and Service Coordination (NASC) agency for as needed services such as Primary Options for Acute Care, and young people with disabilities. On the days of audit there were 121 residents on site. Thirty one of these were assessed as requiring rest home level care and one additional RH level care resident was receiving respite care. There are 89 residents including one under 65years/LTSC resident receiving hospital level care.</p> <p>The organisation's vision, mission, values and annual goals are documented in the business plan 2021, Quality Risk Management Plan and Operational Goals 2021. This is reviewed regularly but last reviewed 15 March 2021 with the board who meet on a monthly basis with the Chief Executive Officer (CEO) to consider all operational and financial business. This plan covers HBH, Gracedale Home and Hospital and Gulf Views Rest Home. Review of the reports to the board showed they are provided up to date information on occupancy rates, health and safety matters, audit outcomes, staffing information, financial reports, information about complaints and compliments received, resident care, quality and other service delivery matters. The CEO advised there have been significant changes and restructure of the organisation since the previous audit and for this a continuous quality improvement has been provided at this audit.</p> <p>The CEO who has been in the role for nine years, has extensive experience as a manager in the health sector and is qualified in business management and leadership. The Director of Nursing (now clinical services manager) has been employed by the organisation for 40 years, is a registered nurse with extensive clinical and managerial experience in aged care. There are two newly appointed GMs one responsible for corporate, property and tenancy manager (a new title) who has experience with building and project management and the other GM is experienced in clinical/quality and the Eden Alternative. The organisational chart has been changed to reflect the newly established roles and to define the executive management team. Review of personnel files and interviews confirmed that all senior management staff are qualified for their roles and maintain their skills and knowledge by attending regular professional development and industry conferences.</p> |

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| <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>CI</p> | <p>The quality and risk management system is well established and integrated across all areas of service delivery. A new policy and procedure set was introduced two years ago and has been effectively rolled out across the organisation. Staff interviewed confirmed the transfer to a new set of forms and policies is being managed well. The policy set in use is industry standardized by an external consultant and all are controlled and reviewed at least two yearly or when changes are indicated. The quality and infection control co-ordinator has worked collaboratively with one of the general managers (GM) clinical/quality to ensure all policies were reviewed and personalised to the organisation. Changes require authorisation at senior management level.</p> <p>The training calendar 2021 was sighted and covers all requirements for ongoing training and training to meet the services contract/agreement with the DHB.</p> <p>Quality monitoring includes regular checks and audits of service delivery and the collection, reporting and benchmarking of quality data. The quality and infection control co-ordinator prepares and collates quality data for external benchmarking and internal reporting and trend analysis. This information is presented and discussed at board level, management meetings, and at the Continuous Quality Information Committee (CQI) meetings. The clinical/CQI committee, which comprises of the clinical/quality manager, the CEO and senior managers, meet monthly to report across their service areas and share quality data. Quality and risk matters are reported and discussed at a range of staff meetings (for example, RN meetings, health and safety meetings, and regular meetings of care partners across shifts in each community). The sample of meeting minutes reviewed showed that resident care, including their adverse events, health status, infections and behavioural concerns, are discussed at RN meetings, and at hospital and rest home staff meetings. Senior managers review incidents/accidents, complaints, staffing, financial and project matters at their meetings and the health and safety committee consider staff injuries and the impact of environmental issues on services.</p> <p>A range of staff are involved in quality and service monitoring (for example, internal audits, quality improvement projects, and other initiatives or methods to improve services). The organisation demonstrated a strong commitment to 'getting things right' and to continuous quality improvement. This was demonstrated by the extent of ongoing quality projects presented at audit and the planned and reviewed approach for implementation of the Eden Alternative which is now embedded across the organisation/community at large.</p> <p>Where audits, incidents, complaints or feedback identify deficits, these are reported verbally and in writing. A range of corrective actions are discussed with relevant people and the most suitable actions are implemented.</p> <p>An ongoing continuous improvement rating is awarded in criterion 1.2.3.6 for successes achieved as a result of implementing internal benchmarking. The organisation continues to participate in the 'QPS' benchmarking programme which compares indicators with similar aged care facilities across Australia and New Zealand. This information is analysed by the senior management team to identify trends and is reported quarterly to the trust board.</p> <p>Risk management processes are integrated with the quality monitoring system. The current risk management plan includes service provision, human resources, natural disaster planning, health and safety, contractual compliance</p> |
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| | | <p>and financial risks. The health and safety committee report all matters that require communication and discussion at staff and management meetings. Environmental checks to assess for health and safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets which provide information about hazardous chemicals are displayed in various locations on site.</p> <p>Health and safety and essential emergency processes are mandatory topics during orientation and as part of the annual staff education plan. The interRAI assessment process identifies each resident's clinical risks and service delivery plans described how these will be mitigated.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. This was confirmed by a sample of accident/incident forms reviewed on the days of audit, other documents related to the collation and analysis of incidents, meeting minutes, board reports and section 31 notifications. Interviews with the quality and education manager, other senior managers, the CEO, GM, RNs, care partners and allied staff, revealed that the adverse event reporting system is well known and understood. Incidents are discussed at shift handover, and trending data is displayed in the staff rooms. Each resident's care record contained a summary of incidents which facilitates a ready review of risks. The event reports showed that people impacted by the adverse event are notified.</p> <p>The event records showed that reporting occurs immediately to the team leader and to the director of nursing, who investigates to determine cause and prevent or minimise recurrence. All the event data is then collated monthly. (Also refer to criterion 1.2.3.6 for timeframes and process) by the clinical/quality manager and the quality/infection control co-ordinator. This data is discussed monthly by the CQI committee, reported monthly to the board and further evaluated by the CEO and other senior managers each quarter. Howick Baptist Healthcare continues to receive three monthly benchmarked comparisons of events against similar size and same scope age care facilities in Australia and New Zealand.</p> <p>Interview discussions and the content of meeting minutes verified the ways in which the system is designed to predict, avoid and/or mitigate adverse events and to ultimately prevent recurrence.</p> <p>All senior managers are conversant with and understand their statutory and regulatory obligations in regard to essential notifications and reporting. There has been one death referred to the coroner (which remains open) and no other police investigations since the previous audit. The organisation has had one DHB report of a resident with a pressure injury which was closed out effectively. There have been no infection outbreaks and all precautions were undertaken during the Covid 19 pandemic as verified in the meeting minutes and infection prevention and control programme reviewed.</p> |

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| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Staff management policies and processes 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 sample of staff records reviewed confirmed the organisation's policies for recruitment and performance management are being consistently implemented. Recruitment, appointment and ongoing employment records are being maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. The orientation programme continues to be reviewed and updated. All new staff now have one to one training on manual handling by the physiotherapist and other subjects related to occupational health and safety before starting work. New staff reported that the orientation process prepared them well for their role. The staff records reviewed contained proof of completed orientation followed by an initial performance review after 90 days.</p> <p>Staff education specific to age care is planned over a two year period and covers a range of topics. Some educational topics are mandatory for staff to attend annually, such as emergency management, infection control, and medicines management (if administering medicines). The RNs and specialist staff are provided with additional training pertinent to their roles or as necessary for them to maintain annual membership with their professional bodies (e.g., physiotherapists, social worker, occupational therapists, and maintenance, domestic and kitchen staff.) The training calendar for 2021 was reviewed. Training evaluations are completed by all who attend the in-service after all educational sessions for quality improvement purposes.</p> <p>The organisation is very focused and invested in ensuring that every staff member fully understands, and practices in ways that enact each of the 10 principles of the Eden Alternative. Howick Baptist Hospital (HBH) are now in their ninth year of implementation. All staff receive an employee handbook when employed which contains the mission statement, the Eden Alternative Ten Principles, history of HBH senior living, organisational structure and lines of accountability and relevant staff information to guide staff. Senior management have created and adopted new approaches to educating staff. The Eden Educational guide developed in house, has proven to be successful and is receiving international recognition.</p> <p>The new roles and changed roles in the senior management team came into effect on 9 February 2021. Staff were informed of the changes but lines of communication remained unchanged.</p> <p>All care staff are expected to commence age care sector training (as outlined in their pay equity settlement) three months after commencing employment, if they do not already have qualifications. At the time of this certification audit care staff have achieved qualifications in age care. As follows:</p> <p>ACE Programme level 2 – 1</p> <p>ACE Advanced – 1</p> <p>Community support services (residential) – 2</p> <p>Community support services L3 - 5</p> |
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| | | <p>Health and Disability and Aged support L3 – 5</p> <p>Activities – Level 4 – 1 (of four activities assistants) and one commencing level 4</p> <p>Certificate in Health and Well Being L3 – 15</p> <p>Certificate in Health and Wellbeing L4 - 22</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>Observations and review of the rosters and interviews with all levels of staff confirmed there are appropriate numbers of staff on site 24 hours a day, seven day as week (24/7) for the number of residents and services required. The number of RNs, ENs and care partners allocated on each shift in the rest home and hospital communities meet the ARCC requirements for the number of residents in care (maximum 129). The organisation employees approximately 190 staff which equates to 88 full time employed (FTE) staff. A full time director of nursing oversees the care being delivered to all residents Monday to Friday. Each community has allocated RNs and team leaders. The safe staffing levels/good employer policy reviewed July 2020 is maintained and implemented.</p> <p>The rest home roster (for 31 residents) has three care partners, a team leader and an EN for the morning shift, a team leader and two carers for the afternoon shift and two care partners at night. Each of the four hospital communities (24 beds each on average) have five care partners and two RNs rostered on for morning shifts, three care partners and one RN in the afternoon and three care partners at night with two RNs overseeing two hospital communities. These rosters are the same seven days a week and the roster clerk and operations assistant interviewed ensured there is at least two staff members with a current first aid certificate on duty at all times (all RNs and ENs are maintaining comprehensive first aid certificates).</p> <p>The staff interviewed said there were sufficient numbers of staff, for the needs of the residents, allocated across all shifts. Additional staff are rostered on when workloads increase for any reason. There has been minimal to no usage of agency staff as the organisation maintains a reliable pool of casual staff.</p> <p>An appropriate number of additional auxiliary staff are on site at various times and days (for example, activities staff (also called care partners) and occupational therapists, physiotherapist/rehabilitation assistants, kitchen staff and cooks (outsourced), cleaners and laundry staff, management, social worker, administration and maintenance staff) for the size and scope of the services.</p> <p>Residents and family members interviewed expressed satisfaction with the availability of staff and the services provided.</p> <p>HBH has very little turnover of staff. Its staff retention rates are much higher than the industry average.</p> |

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| <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 Low</p> | <p>Howick Baptist Home and Hospital has an electronic medication management system in place. The medication management policy identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies.</p> <p>The two RNs who were observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked treatment rooms and medicine trolleys. Staff have individual passwords to access the electronic medicine records. The medicine fridge and medication room temperatures were monitored, and the reviewed records were within the recommended ranges.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs complete medication reconciliation upon residents' readmission from acute services and when medication is received from the pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy. Controlled drugs were 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.</p> <p>The GPs completed three-monthly medication reviews consistently, this was verified on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed.</p> <p>There were three residents who were self-administering medications at the time of audit. Self-medication administration competencies were not reviewed as per organisation's policy; the medicines were not kept in locked drawers in residents' rooms and monitoring of self-administered medicines was not documented consistently as per policy. An area of improvement was discussed and provided in relation to these findings.</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>The meal service is prepared on site by an external contractor and is in line with recognised nutritional guidelines for older people. The meals are served in the respective dining areas. There is a current food control plan and registration issued by the Ministry of Primary Industries. The menu was reviewed by a dietitian in May 2020. The Autumn/Winter menu is in use and it follows a four-weekly cycle. The kitchen manager is chef who is assisted by two other chefs and twelve kitchen assistants. All kitchen staff have completed a safe food handling training. Electronic records of training were sighted. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen manager confirmed awareness on dietary needs of the residents. Copies of residents' dietary requirements were sighted in the kitchen file.</p> <p>Residents' weight is monitored regularly, and supplements are provided to residents with identified weight loss issues. The care partners assist with serving the prepared meals.</p> |

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| | | <p>The kitchen was clean, no expired food was found in the pantry and left-over food was covered and dated. Records of temperature monitoring of food, fridges and freezers are maintained. Regular cleaning was undertaken, and cleaning schedules sighted. Satisfaction with meals was confirmed by residents in interviews, satisfaction surveys and resident meeting minutes. Residents were given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>The interventions documented in the long-term care plans reviewed were adequate and appropriate to address residents' assessed needs and desired outcomes. Observations and interviews with residents and family/whanau 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 residents' individualised needs was evident in all areas of service provision. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet 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>A social assessment and history is completed on admission to ascertain residents' needs, interests, abilities, and social requirements by the occupational therapist. The Eden Alternative principles are incorporated in the assessment. The activities programme is provided by the lifestyle team. The activities programme (social calendar) is planned with input from residents monthly through feedback on what activities they want to participate in. The social calendar was posted on the notice boards in each community.</p> <p>Activities reflected residents' goals and ordinary patterns of life. Individual and group activities are offered. Residents are free to attend activities in any community within the facility either in the rest home or hospital level communities. There is a variety of planned activities including birthday celebrations, baking, monthly theme celebrations, external entertainment, gardening, regular physiotherapy, church services, newspaper reading, walks, movies, Eden meetings, bus outings and household tasks. Spontaneous events are offered on an ongoing basis. A new programme to offer cognitive stimulation therapy combined with chair yoga was introduced for residents with mild to moderate dementia. Residents were observed participating in a variety of activities on the days of the audit. Residents' leisure and household participation was documented in each resident's care plan including the Eden Alternative goals.</p> <p>The residents' participation in activities was recorded daily and activity needs were evaluated as part of the formal six monthly interRAI and care plan review. The satisfaction survey verified residents' and family/whanau involvement in evaluating and improving the social calendar. The interviewed residents and family/whanau confirmed residents' satisfaction with the social calendar.</p> |

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| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>The long-term care plans and short-term care plans were evaluated by the RNs and ENs in a timely manner. Evaluations sighted were individualised and indicated the residents' degree of response to the interventions and progress towards achieving the desired outcome. Changes were made to the care plans where the desired goal was not met. The interviewed residents and family confirmed their involvement in the evaluation of progress and resulting changes. The long-term care plans sighted were signed by residents and family or enduring power of attorney where indicated.</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>A current building warrant of fitness expiring 04 March 2022 was publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for purpose and maintained as confirmed in documentation reviewed, interviews with management and maintenance staff and environmental inspection. Testing and calibration of hoists, electric beds and bio medical equipment occurs annually or more frequently as required. Water temperature monitoring occurs and is recorded monthly. A preventative maintenance schedule is adhered to. Staff confirmed they know the processes they should follow if any repairs or maintenance is required and stated that requests are actioned in a timely manner.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The infection surveillance carried out is in accordance with the agreed objectives specified in the infection control programme and is appropriate for the size and setting of the service. All identified infections were documented, monthly data was collated and analysed. Recommendations and corrective actions to assist with reducing and preventing infections were acted upon. Short term care plans were implemented with appropriate interventions to manage the identified infections. New infections and any required management plans were discussed at handover, to ensure early intervention occurs. Monthly surveillance results were shared with staff in staff meetings. Comparisons against previous months were conducted and the reviewed infection statistics evidenced minimal infection rates.</p> <p>Covid-19 pandemic contact tracing measures were implemented. There was no infection outbreak reported since the last audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p> | FA | <p>The registered nurse/restraint co-ordinator interviewed has been in this role since 2000. On the day of audit thirteen residents were using a form of restraint and five are using enablers. All were documented in the restraint register. The policies and procedures reviewed included definitions that reflect the restraint minimisation and safe practice standard. Education is provided to all staff at orientation and is provided annually. Enablers are only voluntary and</p> |

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| <p>that the use of restraint is actively minimised.</p> | | <p>used at the request of the resident for safety purposes. Restraint is only used as a last resort when all other avenues have been explored. The same assessment and consent process is followed for the use of enablers and is used for restraints.</p> <p>A sample of resident records were reviewed for those using a restraint. Full assessments were completed prior to implementing a restraint intervention and that alternatives had been tried. Approval is granted by the restraint committee and valid consent is obtained by the resident or their authorised next of kin or enduring power of attorney (EPOA) if needed.</p> <p>All new staff are provided with information about the restraint minimisation policy, philosophy during orientation/induction.</p> |
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|-------------------|---|--|--|
| <p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p> | PA Low | <p>There is a self-medication administration policy in place to guide staff on processes to ensure this was managed in a safe manner. The policy in use stated that self-administration competency is to be reviewed six-monthly. The organisation is in the process of reviewing the self-medication administration policy. Two sighted competency forms for self-administered eye drops and vaginal cream evidenced that the competency reviews were being completed at least annually and one resident did not have a review documented. The medicine was not stored in locked drawers and documentation to evidence regular monitoring of self-administered medicines was not completed consistently. The residents have individual rooms. In interviews conducted, the concerned residents confirmed their competency in managing the medicines independently.</p> | <p>Three out of three residents who self-administer medicines did not have their competencies reviewed in a timely manner as per organisation's policy.</p> <p>Monitoring and documentation of self-</p> | <p>Provide evidence that self-medication administration procedures are completed as per organisation's policy.</p> <p>180 days</p> |

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| | | | <p>administered medicines was not completed consistently as per organisation's policy.</p> <p>Self-administered medicines are not stored appropriately as stated in the medication policy.</p> | |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|-------------------|--|---|
| <p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p> | CI | <p>Due to the organisation expanding over the past five years with the purchase of a new facility and a facility that is fully managed by this organisation since the previous audit it was timely to review the current executive leadership team and restructure the total organisation since the previous audit. The business plan with the Eden Alternative philosophy and the ten principles being totally embedded throughout the plan was reviewed to ensure the best structure moving forward. The Board and the CEO took the time to understand how the new changes were affecting people’s roles and how the organisation could create the best team for the future. Earlier this year the new team was announced. The business plan</p> | <p>Having fully attained the criterion the service can in addition clearly demonstrate that the board and the CEO have in addition to reviewing the business plan, have implemented additional new strategies to continuously improve service provision and to meet the rapid growth of the organisation. Outcome focused changes had to occur such as the increasing of further senior management roles. Continual high occupancy rates and the purchasing of another aged care facility and the leasing of an existing aged related care service since the previous audit, added increased pressure onto the CEO from a business perspective. Since the review of the organisation occurred, two general manager (GMs) roles have been developed and both currently report to the CEO. Each strategy is documented with who is responsible and roles are clearly defined (refer to 1.2.7) in the business plan reviewed. Significant improvements have already been made in relation to resident safety and the resident/family surveys provided excellent feedback about the service. Positive satisfaction was acknowledged from residents, staff and family members interviewed regarding all aspects of service provision and the smoothness of the transition of change of the organisation was appreciated. All newly</p> |

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| | | demonstrates and reflects the organisation mission statement and how the new roles will enhance this. The business plan timeframes are set to ensure changes are recorded as they are implemented and to ensure these are constantly evaluated for quality improvement purposes. | appointed staff report regularly to the CEO and staff to the team leaders of each community and/or to the clinical services manager. The mission statement to provide excellent, compassionate and responsive care for older people, especially those who are ill, frail or vulnerable is well projected through the community at large and staff interviewed and family stated the residents' needs are effectively met. |
| Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The collection, collation, analysis and feedback of quality improvement data is well established as an effective methodology for monitoring service delivery. This is well embedded across the organisation since the previous audit and staff are well informed and the system in place demonstrates this quality improvement process continues at a high standard. The external benchmarking works effectively and if any trends are identified they are quickly and positively addressed in a timely manner. The staff are very engaged in the quality data being presented to them and are continually striving to better themselves and the outcomes for the residents in their communities. The new team leader roles have ensured that staff continue to report any incidents occurring in their individual community and understand the significance of why they are reporting these events. | Having fully attained the criterion the service can in addition to this can clearly demonstrate that the new approach to benchmarking has continued since the previous audit. This organisation is a high performing organisation resulting in high occupancy rates at all times across all facilities within the organisation. The process implemented has resulted in identifying concerns or issues more quickly and allowing immediate action to occur. It has become and continues to be a reflective learning experience. Staff interviewed in a large group contributed freely and demonstrated how much they were engaged and involved with quality data and the ongoing seeking of outcomes for improvement of service delivery for the residents. Evaluations have been ongoing and positive results are being obtained and shared on a monthly basis. Further internal audits will be arranged with the more recent purchase of another rest home facility and another facility which is managed by this organisation for continuous quality improvements for residents that reside at these two facilities as well as Howick Baptist Home and Hospital. Residents are kept well informed of outcomes in the Howick Baptist newsletter which all residents receive. Copies were available at reception. |
| Criterion 1.3.7.1 Activities are planned and | CI | The continuous improvement rating for the activities programme attained in the previous audit was maintained. The Eden | Having fully attained the criterion the service can in addition clearly demonstrate an ongoing review and analysis process of each of the activities programmes provided in each community. Staff are fully |

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| <p>provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | | <p>coach continues to work with the OT, the lifestyle team, and the nursing team. The new social calendar is in use and the Eden alternative philosophy is incorporated into daily care. Ongoing monthly multidisciplinary meetings are held with the registered nurses from each community, OT, physiotherapy, care partners and lifestyle team to evaluate and assess progress of the Eden Alternative philosophy. There are several quality improvements in relation to the activities provided which include aims and objectives, the goals that were trying to be achieved and an evaluation. The evaluations also include feedback from the residents, all of which were evidencing positive outcomes and increased enjoyment with the programmes provided in each community.</p> | <p>committed to providing an activities programme that continues to be motivational, enjoyable and interesting to prevent residents from feeling bored, unhappy or lonely. The Eden philosophy is well embedded into each community and the responses from residents was positive at interview. There has been increased staff knowledge, confidence and skill in resident self-worth and developing and increasing resident's skills and participation in meaningful activities. Positive outcomes have been measured in staff, resident and relative satisfaction.</p> |
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End of the report.