# Paramount Healthcare Limited - Paramount Healthcare

## Introduction

This report records the results of a Provisional Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Q-Audit Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Paramount Healthcare Limited

**Premises audited:** Paramount Healthcare

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 9 July 2021 End date: 9 July 2021

**Proposed changes to current services (if any):** Paramount Healthcare intends to take ownership of the rest home on 1 August 2021 depending on the outcomes of the provisional audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 8

# 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.

## General overview of the audit

Kimberley rest home is in the town of Palmerston in South Island, Otago region. The service provides rest-home level care for up to 25 residents. There were eight (8) residents on the day of the audit. A change in ownership is anticipated to occur on 1 August 2021. The service is privately owned and operated by two owners/directors. The rest home is managed by the facility manager (FM) who is one of the owner/directors supported by the registered nurse (RN) and activities coordinator/supervisor. Residents and families spoke positively about the care provided. There have been no significant changes to the facility or services since the last audit. The current owners/directors and the prospective director were interviewed.

This provisional audit was conducted to assess how well prepared the prospective owners are to own/manage a rest home. This provisional audit is based on the previous certification audit results which was against the Health and Disability Service Standards and the service contract with the District Health Board. The audit process included a review of policies and procedures, the review of residents’ and staff files, observations, and interviews with residents, relatives, staff, and management.

There were no areas identified requiring improvement during the certification audit conducted in April 2021.

## Consumer rights

Residents of Te Rangimarie Aged Care Limited - Kimberley Rest Home and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) on admission, and these are respected. Residents’ privacy, independence, individuality, and dignity are supported. Staff were observed to 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.

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 organisation has linkages with a range of specialist health care providers to enable them to support best practices and meet resident’s needs.

The complaints process meets consumer rights legislation, and a complaints register is maintained.

## Organisational management

The organisation is currently governed by a couple who are owners/directors. The operation of the facility is managed by suitably qualified personnel and organisation performance is closely monitored by the owner/directors. A transition plan outlines the focus for the potential owner.

The prospective owners have the required knowledge and skills to manage a rest home and will be supported by the current registered nurse and staff at the service. Business and quality plans include the scope, direction, goals, values, and mission statement of the organisation. The business, quality risk, and management plan document the organisation’s goals and objectives. Effective reporting processes are in place. The organisation’s quality and risk management system is used to ensure service delivery is of a consistently high standard. It includes an audit programme and corrective actions are developed and implemented when deficits are identified.

These are monitored, and the management ensures all data is analysed, collated, and shared with staff. Adverse events are reported and recorded. The prospective provider is aware of legislative and compliance requirements, Policies and procedures support service delivery, best practice, and were current and reviewed regularly. Established processes are in place to facilitate client entry to and exit from services. Residents’ information is managed efficiently, contains a level of detail relevant to the service, and meets health record requirements.

Human resource processes support good employment practices. All staff receive an orientation. Ongoing training is provided, and staff competencies are assessed and monitored. Current annual practicing certificates are kept on file. Police checks are undertaken. There are always adequate numbers of skilled staff on duty.

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

## Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriately and efficiently managed. When a vacancy occurs, the relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short-term care plans are developed to manage any new problems that arise. All residents’ files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed regularly. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is good. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is provided by an activity’s coordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility vehicle is available for outings.

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

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

## Safe and appropriate environment

Kimberley Rest Home meets the needs of residents and is clean and well maintained. Residents have an individual bedroom decorated with personal belongings. All rooms had adequate natural light, ventilation, and heating.

Appropriate policies and procedures are available along with product safety charts. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness which expires on 11 September 2021. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days.

The prospective owners have plans to revert the service to a rest home and dementia level of care in the near future.

## Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no residents using restraint or enablers, at the time of audit. Use of enablers is voluntary and is used for the safety of the residents, in response to individual requests. Staff have knowledge regarding the restraint and enabler policy and processes. Training on management of challenging behaviour is provided.

## Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the district health board.

The programme is reviewed annually.

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, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 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 | Te Rangimarie Aged Care Limited - Kimberley Rest Home (Kimberley) has policies, procedures, and processes in place to meet its obligations about the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, 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.  The prospective/owners demonstrated a good understanding of the consumers' rights legislation. The other owner/director who is going to be the facility/clinical manager has been a care manager in the aged care sector for over two years now. |
| 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 | 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 informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent are defined and documented, as relevant, in the resident’s record. Staff were observed to gain consent for day-to-day 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 related to the Advocacy Service were also displayed 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 service has a documented complaints management policy and procedures in place that align with Right 10 of the Code. The service’s complaint register is detailed regarding dates, timeframes, complaints, and actions taken. Complaints sighted in the register were as follows; 2019 three (3), 2020 two (2) and one (1) anonymous/external, and nine (9) verbal complaints in 2021. The rest have been resolved except for one anonymous complaint received via the DHB that was still open. Documentation regarding this was sighted and all correspondence was sent to DHB. The FM reported that they were awaiting communication from the DHB programme manager before closing it off in the register. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and families are advised of the complaints process on entry to the service. This includes written information about making complaints. Residents interviewed describe a process of making complaints that includes being able to raise these when needed or directly approaching staff or the facility manager. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed at Kimberley, reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service as part of the admission information provided and discussion with staff. The Code is displayed in the area foyer and common areas throughout the facility. A poster on how to access the Nationwide advocacy service is visible in the lounge. Information on how to make a complaint and feedback forms are available at the front entranceway. |
| 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 their families confirmed that they receive services from Kimberley in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room. There is a double room at Kimberley and is used when couples request to share a room. At the time of the audit, this was empty.  Residents are encouraged to maintain their independence by joining in community activities, visiting the local supermarket, and doing their shopping, and participating in clubs of their choosing. Care plans included documentation related to the resident’s 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.  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. Residents and family interviews verified no evidence of abuse and neglect has been experienced or sighted at Kimberley. |
| 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 | Staff at Kimberley support the one resident who identifies as Māori to integrate their cultural values and beliefs. The principles of Te Tiriti O Waitangi are incorporated into day-to-day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on Tikanga best practices is available from the local Iwi if needed. Interview with the resident verified that staff acknowledge and respect the individual’s 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 verified that they were consulted on their culture, values, and beliefs and that staff respected these. Resident’s personal preferences required interventions, and special needs were included in care plans reviewed. An individualised approach was evident in all aspects of the residents’ care and routines. 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 and family members 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. The registered nurse (RN) has records of completion of the required 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 RNs at the local medical centre, wound care specialists, assessment and rehabilitation support, and health services for older people at Southern District Health Board (SDHB), and on-going in-service training of staff. The general practitioner (GP) allocated to caring for Kimberley residents has left the region at the beginning of the month, and a replacement has not yet started. GP cover in the interim is being provided by several other GPs. Interview with the practice manager 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 and access their professional networks to support contemporary good practice.  Other examples of good practice observed during the audit included a commitment to individualised resident care, a high level of integration with the community in the provision of activities, and prompt attention to GP requests and follow-up. The RN accesses a range of online learning hubs to enable the maintenance of best practice standards.  The potential owner confirmed during the interview that they are intending to keep the existing systems in place around clinical practice and will support staff to complete dementia level four (4) training. The other owner/director who is a registered nurse and currently working as a care manager in the aged care sector is a qualified Career Force workplace assessor. |
| 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.  Staff knew how to access advice on accessing interpreter services. All present residents were able to speak English.  A resident with communication difficulties had clearly defined strategies to assist the staff in communicating with the resident. Communication cards at times were used. |
| 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 service is up for sale and the prospective owners have commissioned a provisional audit. Kimberly Rest Home is potentially to be purchased by the new prospective owners (Paramount Healthcare). The prospective owners have an established organisational structure outlined in their business and transitional plan. The future arrangements will be prospective owners will have roles of being directors and be in the management supported by the current staff at Kimberly. A current business plan was sighted which is based on delivered service, objectives, and performance measures. The purpose, values, scope, direction, and goals of the organisation were clearly outlined.  The transition plan and business plan sighted include how the prospective owners will be transitioned into the running and management of the service under the support of the current management. The business plan includes time frames for maintaining the current quality system, policies, and procedures, staffing, and service delivery. The prospective owner intends to revert the current service to a rest home and dementia level of care service. Other future changes will be considered on a need basis, and these are covered in the business plan. The planned settlement date is 1 August 2021. The prospective owners and the current owner/director (FM) reported that the planned transition time will be for 30 days or more if required. All files sampled evidenced that residents were receiving the appropriate level of care.  The prospective owners have vast experience in the health and information and technology (IT) sector in New Zealand. The other owner/director is a registered nurse with over three (3) years of clinical experience and is currently working as a care manager in the NZ aged care sector since August 2019, qualified career force workplace assessor, and has a diploma in health service management. The other director has an overseas qualification in mechanical engineering and a NZ diploma in information technology and business. In an interview conducted the prospective owner/director reported that they will be responsible for the management of the facility. The other owner/director will be the facility/clinical manager supported by the current registered nurse while the other will be a managing director and a maintenance person.  The service is operated by Te Rangimarie Aged Care Limited. The owner/directors and RN are suitably qualified and maintain professional qualifications in management, and clinical skills. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The owner/director interviewed reported that renovations and maintenance issues are completed on an ad hoc basis.  The service holds contracts with the district health board (DHB), ministry of health (MOH) for the provision of the rest home, respite, and day-care services. There were eight (8) residents receiving services on the day of the audit. All were assessed as needing rest home level of care.  The prospective owner had visited the service and is being supported by the current owners to transition into the service. |
| 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 | Day-to-day activities are the responsibility of the owner/director (FM) with the support of the registered nurse. In interview conducted the potential owner reported that, when absent the current RN will provide clinical oversight and day-to-day clinical management of the service. Following the purchase, the management role will be taken over by the potential owner who will assume the role of a Facility/clinical manager. The new management role will involve accounting, administration, staffing, and overall management of the service. The transition plan states that the owner intends to be onsite during the week with considerable input initially. The potential owner will be onsite for at least 40 hours a week and on-call on a 24-hour basis. |
| 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 documented planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents, and accidents including infection surveillance.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team and staff meetings. The RN reports to the owner/directors daily, weekly, and monthly while the FM is away on leave. This was further confirmed by the owner/director in an interview conducted. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly, and the previous survey showed an 80% response rate which was positive.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practices and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes.  The FM/owner-director described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The FM and RN are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.  The prospective provider intends to maintain the same quality and risk management system. The schedule of internal audits will continue, as will other quality-related activities. The prospective provider was aware of legislation requirements and had considered risks associated with the transition and the aged care sector. |
| 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 | The service has documented policies and procedures on adverse event reporting. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. A sample of completed neurological observation and incident forms were sighted. Information on adverse events data is collated, analysed, and reported to the staff and management, respectively. Staff document adverse and near-miss events on an accident/incident form. All incidents were investigated, action plans developed, and actions followed up in a timely manner. There is an open disclosure policy in place. In the interview conducted residents and family/whanau confirmed being informed of any incidents by staff. This was reiterated by the prime nurse who reported that adverse events and any change in the residents’ condition are noted and reported to the medical centre for GP to review. The prime nurse visits the facility often to give in-service training on various topics to staff.  The FM and RN described essential notification reporting requirements, including pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.  The prospective owners understand their statutory and/or regulatory obligations about essential notification reporting and notify correct authority where required. |
| 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 | Human resource management processes follow good employment practices and meet the requirements of legislation. This was evidenced in all staff files sampled. Current annual practising certificates for the RN, GP, Pharmacist, and podiatrist are kept on file. Police checks were undertaken. Continuing education is planned on an annual basis, including mandatory training requirements. 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. The current RN is interRAI trained and competency assessments were sighted in files sampled. The orientation/induction package provides information and skills around working with residents assessed as requiring rest home care and respite and including those that attend the day-care programme. Staff reported that they receive ongoing training to meet the needs of residents. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal.  Residents and family interviewed stated that staff are knowledgeable and skilled.  The prospective provider intended to make no changes to human resources processes and reported that additional staff will be employed when needed. |
| 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 care delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on-call schedule is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have a staff member on duty with a current first-aid certificate. The RN works four days a week during the day. There is a registered nurse on-call 24/7 to cover this facility.  The FM/owner-director reported that staffing levels will be increased, and this will be reviewed on an ongoing basis depending on occupancy and acuity.  The prospective owner anticipates that staffing will remain at the current level and changes will occur as needed in the future. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | A resident register of all current and past residents is maintained. The resident’s name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents’ information sighted. 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 in the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived paper 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 | Residents are admitted to Kimberley when they have been assessed by the local Needs Assessment and Service Coordination (NASC) Service as requiring the level of service Kimberley provides. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the RN. They are also provided with written information about the service and the admission process.  Family members 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. |
| 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 coordinated manner, with an escort as appropriate. The service uses the SDHB ‘yellow envelope’ system to facilitate the transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, 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 the transfer was managed in a planned and coordinated manner. The family of the resident reported being kept well informed during the transfer of their relative. |
| 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. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of the audit. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use-by dates. Clinical pharmacist input is provided on request.  Controlled drugs when required are stored securely in accordance with requirements and checked by two staff for accuracy in administration. There is no resident requiring controlled drugs at the time of audit. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries when used in the past.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.  There was one resident who self-administered medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used at Kimberley. |
| 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 at Kimberley is provided on-site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns, and the summer menu has been reviewed by a qualified dietitian on 28 December 2020. Recommendations made regarding the menu have been attended to. An additional recommendation made by the dietician advising an onsite visit (post-Covid) a review of purchasing quantities and a policy review should occur, has yet to be undertaken. Interview with the owner verifies this will be attended to on his return from Australia within the next month.  Access to the kitchen in the morning is limited to kitchen staff. No residents or care staff were observed entering food preparation areas, during the time of audit. The cook in the morning prepares the evening meal. During the morning, the cook does not aid caregivers. The afternoon caregiver spends time in the kitchen heating the pre-prepared meal and dishing up the tea meal. This is done at a time prior to cares being commenced. Safe food handling processes are in place and PPE is provided to ensure infection control processes are maintained by care staff when undertaking kitchen duties in the evening.  An up-to-date food control plan is in place at Kimberley. The verification audit was undertaken by the Waitaki District Council on 20 January 2021. Five areas of corrective action were identified and have been attended to. An 18-month verification continues with the next audit due on 20 June 2022.  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken safe food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences, any special diets, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys, and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. |
| 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 | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment is made to the NASC and a new placement found, in consultation with the resident and whānau/family. 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 | On admission residents of Kimberley are initially assessed using a range of nursing assessment tools such as pain scale, fall risk, incontinence, skin integrity, nutritional screening including weight monitoring, and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long-term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. The long-term care plans reviewed provided evidence of ongoing assessments of incontinence, weights, and fall assessments.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least every six months unless the resident’s condition changes. Interviews, documentation, and observation verifies the RN is familiar with the requirement for a reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. Evidence of falls is recorded in residents' progress notes and on an incident form. A post-fall assessment by the RN is documented.  All residents have current interRAI assessments completed by one trained interRAI assessor on site. InterRAI assessments are used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed, and include attention to continence, weight loss, and fall management.  Care plans reviewed included a behaviour management plan for a resident with behaviour that challenges.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported 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, observations, and interviews verified that the provision of care provided to residents of Kimberley was consistent with their needs, goals, and plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The manager of the local medical practice when interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs, and specifically in relation to incontinence and monitoring of product use.  Resident interviews verified continence needs are met in a timely and appropriate manner. |
| 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 planned by an activities coordinator, who is undertaking training in diversional therapy and has worked at Kimberley for nine years. The activities coordinator works 14 hours a week, either providing the programme or providing the plan that enables care staff to implement the programme. A volunteer from the community attends and provides craft activities to those who enjoy crafts one day a week. When the activities coordinator is absent care staff provide the activities. Monitoring of the resident’s participation in activities is documented.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal care plan review every six months.  The planned monthly activities programme sighted matches the skills, likes, dislikes, and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include several outings to community events, for example, RSA meetings, attendance at community clubs, attendance at local shows, visits to a local farm to make butter, visits to another rest home, indoor bowling at the local bowling club, and shopping at the local supermarket. Other in-house activities include gardening, knitting, newspapers, cooking a meal of the resident’s choice, cards, and bingo.  The activities programme is discussed at the residents’ meetings each month and minutes indicate residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with activities and involvement in planning future events.  Residents interviewed confirmed they find the programme meets their needs. |
| 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. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans are consistently reviewed for infections, pain, weight loss, changes in medications, changes in management regimes, and progress evaluated as clinically indicated. Wound care plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in the 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 a referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. Referrals are followed up regularly by the RN or the GP. The resident and the family 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 an accident and emergency service 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 | The service has a documented process for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The owner/director is responsible for minor maintenance issues while other requirements are externally contracted. The service uses liquefied petroleum gas (LPG) for cooking and laundry purposes. The cylinders are stored securely outside, and the test certificate was current. Staff responsible for cleaning have completed the required chemical handling training and ensure adequate stock is held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant staff training. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A spill kit is available and accessible if needed.  There is provision and availability of protective clothing and equipment and staff were observed using them. |
| 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 is publicly displayed. Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with owner/director, and observation of the environment.  The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. Residents’ rooms have direct external access to courtyards and garden areas. There are ramps to enable disability access. Residents can walk around freely throughout the facility and grounds which are securely protected. External areas are safely maintained and are appropriate to the resident groups and setting.  Residents and family/whānau confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and that they are happy with the environment.  The prospective owner/director reported that planned changes to revert the service to provide both rest home and dementia level of care will be communicated and relevant authorities notified in a timely manner. |
| 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 adequate numbers of accessible bathrooms and toilet facilities throughout the facility. Communal toilets and showers have a system that indicates if they are vacant or occupied. These bathrooms are situated near the residents` rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. There are seven rooms with a toilet and hand washing basin. Records of hot water temperatures are maintained to ensure that the water remains at a safe and consistent temperature. A visitor and staff toilet is available at the facility. |
| 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 their bedrooms safely. There are 24 single bedrooms of which seven (7) have a toilet and hand basin and one double room. Personal privacy is maintained. Rooms are personalised with furnishings, photos, and other personal items displayed. There is room to store mobility aids, hoists, and wheelchairs. The facility has one sling hoist with the current functional test conducted. Manual handling training is mandatory for all staff. Staff and residents confirmed the adequacy of bedrooms. |
| 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 dining and lounge areas are spacious and enable easy access for residents and staff. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. All furniture is safe and suitable for the resident groups in each care setting. |
| 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 | All laundry is washed on-site or by family members if requested. Family/whānau, interviewed expressed satisfaction with the laundry management and that clothes are returned in a timely manner. There were no designated cleaning personnel and care staff involved in cleaning have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. A spill kit is available if required. Material data sheets are available in the laundry and the sluice room for staff to access when required. Cleaning and laundry processes are monitored through regular feedback from staff and family/whānau, internal audit programme, and corrective actions are acted upon. Care staff were observed managing the laundry services and the laundry area was tidy and clean on inspection. The environment was clean, furniture and fittings were clean and well maintained. The resident and family expressed satisfaction with the cleanliness of the facility. Care staff demonstrated a sound knowledge of the laundry processes. There is a clear separation of clean and dirty areas in the laundry. |
| 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 the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The most recent fire drill was conducted on 11 December 2020 and the fire evacuation audit was completed on 12 December 2020. The current owners/directors reported that they were waiting for a confirmation date of the next fire drill from the fire service department. The orientation programme includes fire and evacuation procedures. 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 for cooker/barbecue, were sighted and meet the requirements for the eight (8) residents at the service. Evening and night-time security is managed by the staff. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff responds promptly to call bells. |
| 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, opening external windows and some have doors that open onto the outside garden or small patio areas. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required in residents’ rooms and 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 | Kimberley provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external advisory company. The infection control programme is reviewed annually.  The RN is the designated infection control coordinator, whose role and responsibilities are included in the RN job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and tabled at the quality/risk/staff meeting. Infection control statistics are entered in the organisation’s electronic infection database.  Signage at the main entrance to the facility requests anyone who is or has been unwell 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. Staff interviewed understood these related responsibilities. |
| 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 infection control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken training in infection prevention and control and Covid-19 update on 24 February 2021, as verified in training records sighted. Well-established local networks with the infection control team at the SDHB exist.  The infection control practitioner from SDHB visited Kimberley on 15 January 2021 and reviewed all infection control practices and policies. Interview with the ICC verifies no areas requiring attention were identified. The coordinator 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.  A good supply of personal protective equipment is available. Kimberley has processes in place to manage the risks imposed by Covid-19. |
| 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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified 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 | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. The content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.  In preparation for the effective management of Covid-19, staff have had training in Outbreak management in November 2020, Correct use of PPE gear, covid-19 update, and handwashing in February 2021. |
| 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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract, and skin infections. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors, and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation’s electronic infection database. Graphs are produced that identify trends for the current year and comparisons against previous years. |
| 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. Definitions of restraint and enablers are consistent with the standard. Residents are supported in maintaining and promoting independence and safety. Records sampled to confirm that staff receive ongoing education on restraint/enablers and challenging behaviour. There were no residents using restraint nor enablers on the day of the audit.  The prospective owner/directors are aware of their responsibilities in regard to restraint minimisation and safe practice as they have plans to provide dementia level of care services. They reported that extra staff will be employed with at least Career Force level four (4) dementia qualification. |

# 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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| No data to display |

# 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.