# Springvale Manor Limited - Springvale Manor Rest Home

## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:** Springvale Manor Limited

**Premises audited:** Springvale Manor Rest Home

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

**Dates of audit:** Start date: 2 November 2021 End date: 3 November 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:** 19

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Springvale Manor provides care for up to 27 residents at rest home and secure dementia level of care. On the day of audit there were 19 residents.

This surveillance audit was conducted against a subset of the relevant Health and Disability standards and the 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, management, and general practitioner.

The service has a mission that supports residents to maximise their physical and emotional wellbeing.

The service is managed by an experienced manager and a registered nurse. Residents and relatives interviewed spoke positively about the service provided.

Eleven of the 15 shortfalls identified at the previous audit have been addressed. These related to review of policies, internal audits, training, integration of records, timeframes, involvement of residents in care planning, referrals to other services, medication management, the environment and equipment, emergency water supplies, infection control programme review and surveillance.

There continues to be improvements required around the quality and risk system, timeframes, care plan interventions, and evaluation of care plans remain areas for improvement.

This audit identified a further shortfall around wound documentation.

## 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. |

The service has a culture of open disclosure. Families are regularly updated of the resident’s condition, including any acute changes or incidents. The complaints process is implemented and managed in line with the Code of Health and Disability Consumers’ Rights.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

A quality and risk management programme is documented. Data is collected and analysed, and changes are made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified. Residents receive appropriate services from suitably qualified staff. An orientation programme is in place for new staff and an annual training plan is documented. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The service has assessment processes and resident’s needs are assessed prior to entry. There is an information pack available for residents and families/whānau at entry. The RN or EN is responsible for assessments, care plans, interventions, and evaluations. The general practitioner reviews residents at least three-monthly. Other allied health professionals are involved in the care of residents.

A diversional therapist coordinates and implements an activity programme that meets the abilities and individual recreational needs of all residents. There are integrated group activities such as entertainment and weekly outings into the community.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies.

All meals and baking are prepared and cooked on site by qualified cooks. Resident's individual dietary needs and dislikes were identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks are available 24-hours.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy that includes comprehensive restraint procedures. The facility manager (EN) is the restraint coordinator. At the time of the audit there were three residents assessed for restraint use, with one using a restraint daily. There were no residents using an enabler.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 16 | 0 | 1 | 4 | 0 | 0 |
| **Criteria** | 0 | 51 | 0 | 1 | 4 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints are being managed in line with Right 10 of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code). Residents (three rest home) and family members interviewed advised that they are aware of the complaint’s procedure. Families interviewed stated they had every confidence any complaint would be followed up should they have cause to raise one and the facility manager and registered nurse are both very approachable.  A record of complaints, both verbal and written, is maintained by the facility manager. There have been no complaints on the complaints register for 2021 (year to date) and none for 2020. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints, and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the contact sheet, which is held in each resident’s file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified that family are kept informed. Relatives interviewed (two dementia) stated they are kept informed when their family member’s health status changes or if there has been an adverse event.  An interpreter policy and contact details of interpreters are available.  Family/enduring power of attorney (EPOA) are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and has specific information relating to the dementia level care unit.  Residents and families confirmed they received regular communication and updates regarding Covid-19 levels, restrictions, and associated infection control measures. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Springvale Manor Rest home provides care for up to 27 residents at rest home and secure dementia level of care. On the day of audit there were three rest home residents in the five rest home beds and 16 residents in the 22-bed dementia unit. All residents were under the ARRC contract.  The directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. The manager was able to describe the company quality goals. The service organisation philosophy and strategic plan reflect a person/family centred approach to all services. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2021 business plan that outlines objectives for the period.  The service is managed by an experienced manager (an enrolled nurse) who was the assistant manager prior to this role. The manager is experienced in elderly care management both in New Zealand and Australia. She reports to one of the directors monthly and is supported by a registered nurse (RN) who works full time Monday to Friday. The registered nurse has had experience and training in the care of older people with dementia and the ageing process and works full time Monday to Friday. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home (sighted). |
| 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. | PA Moderate | There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service’s business plan includes clear and timebound objectives to enable evaluation of progress. The shortfall in this regard identified at the previous audit has been resolved  Discussions with the manager reflected staff involvement in quality and risk management processes. Resident and relative surveys are completed with 2020 and 2019 returns sighted. The 2021 survey is currently in process.  The service has bought in and embedded a quality management system which includes all relevant policies. These policies are now current, and the shortfall related to policy reviews identified at the last audit has been satisfied.  There is a quality monitoring programme to monitor contractual and standards compliance and the quality-of-service delivery in the facility. There are clear guidelines and templates for reporting. The facility collects, analyses, and evaluates data. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule and corrective actions being implemented when service shortfalls are identified and signed off when completed. The shortfall related to audits at the certification audit has also been satisfied. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.  Action plans are developed when service shortfalls are identified and followed up. However, the reporting of quality data and outcomes to staff meetings remains an area for improvement. Resident and relative surveys are completed with 2020 and 2019 returns sighted. These confirmed resident and family satisfaction with the service.  Health and safety policies are implemented and monitored by the manager. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies.  Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification, and meeting of individual needs. |
| 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 | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective action. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of ten incident/accident forms identified that forms were fully completed and include follow-up by the manager and RN. Neurological observations are completed for any suspected injury to the head. The manager was able to identify situations that would be reported to statutory authorities. There has not been any requirement to report a section 31 to HealthCERT since the last audit. |
| 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 | There are human resources policies to support recruitment practices. The register of RN, EN and external health professionals practising certificates (e.g., GP, physiotherapist, pharmacy, podiatry, dietitian) is maintained. Five staff files were reviewed (one RN, one DT, two HCAs, and one cook). All files contained relevant employment documentation including a signed employment agreement and job description, and reference checking. Performance appraisals are completed a minimum of annually.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed stated that new staff are adequately orientated to the service on employment, which includes being buddied with more experienced staff. Evidence of completed orientation programmes were sighted in all five staff files reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice, including how to implement activities and therapies for dementia level clients.  There is a two-yearly education plan in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The service provides regular training for staff including impromptu toolbox talks. The previous audit finding related to the provision of staff training has been fully satisfied. Staff complete competency assessments that are specific to their job role and responsibilities.  The manager (EN) has completed interRAI training and the RN is booked for training. HCAs are encouraged to complete their Careerforce qualifications and of the 19 staff who work in the dementia unit, 11 have completed the dementia unit standards, and eight are in the process of attaining them. This includes the diversional therapist and diversional therapy assistants.  Across all HCAs employed outside of the dementia unit, one has achieved level 4, seven level 3, nine level 2 and there are four level 0.  A first aid trained staff is always on duty (24/7).  Staff members interviewed confirmed they received regular communication and updates regarding Covid-19 levels, restrictions, and associated infection control measures. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. The RN and the manager are on site Monday to Friday. The manager and RN share on call when not on site.  The service is staffed as one unit with the RN and EN/senior HCA based in the dementia unit; rosters are as follows:  The dementia unit has twenty-two beds with sixteen residents and the rest home with five beds and three residents.  AM: Four HCAs: Senior 0800-1600, one HCA 0700-1500 and two HCAs 0800-1600 (one HCA covers the rest home wing).  PM: Two HCAs working 1600 to midnight (one in dementia unit and one in rest home), and one senior HCA working 1600 until midnight in the dementia unit.  There is one senior HCA and one HCA on night shift.  Staff reported that staffing levels are adequate for current occupancy. Residents and relatives stated there were adequate staff on duty at all times. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant HCA, EN or RN including designation. Files are integrated, and include progress notes, short-term care plans and long-term care plans (link 1.3.5.2). The shortfall related to file integration identified at the previous audit has been fully satisfied. |
| 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 | Ten medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. All clinical staff (RN, EN and senior HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The registered nurse and senior HCA interviewed could describe their role regarding medication administration.  The service currently uses blister packs for regular medication and ‘as required’ medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications are checked weekly and signed on the checklist form. All eyedrops have been dated on opening. There were no residents self-medicating on the day of audit and no standing orders in use.  The GP reviews the use of antipsychotic medication and if required, makes a referral to the psychogeriatrician.  The shortfalls related to medication management around expired medications, standing orders, controlled drug checks and the temperature of the medication room identified at the previous audit have been fully satisfied. |
| 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 | All meals at Springvale Manor are prepared and cooked on site. There is a food control plan expiring January 2022. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are all within the accepted ranges. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller, and freezers.  Food surveys and one-to-one interaction with kitchen staff in the two dining rooms (both adjoin the kitchen) allow the opportunity for resident feedback on the meals and food services generally. There is a four-weekly seasonal menu with dietitian review and audit of menus. The menu is adapted to ensure resident’s food preferences are considered. Finger foods and snacks are available for residents over a 24-hour period.  Adapted cutlery, sipper cups and lipped plates are available for resident use. Dietary profiles are completed on admission and likes and dislikes and any changes to dietary needs are communicated to the kitchen via the RN/EN. A dietitian is available on request. Supplements and fortified foods are provided to residents with identified weight loss issues. Two cooks (interviewed) were familiar with all residents’ likes and dislikes and those residents with specific dietary needs.  Relatives confirmed on interview that there are always nutritious snacks available for residents to eat. Relatives also reported that meals are well presented, and that staff assist those residents in the dementia unit who require help with food and fluid intake. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Five resident care plans were reviewed, however there were no care plans available (or could be located) for two resident files (one rest home and one dementia). One care plan (dementia care) had not been updated to meet the resident’s current needs and supports including chest pain and supra-pubic catheter care. Resident files for three residents on restraint were reviewed and did not include risks and interventions associated with the use of restraint. These items remain an area for improvement as identified in the previous audit.  Short-term care plans are used for changes to care or health and reviewed regularly by the RN and signed off when the problem has been resolved. These were sighted for skin tears, behaviour incidents, infections, and falls.  There was documented evidenced of resident (as appropriate) and family/whānau involvement in the care plan process, and the care plans sighted identified allied health professionals involved in the care of the resident. The shortfalls related to family/whānau involvement and involvement of health professionals identified at the previous audit have been fully satisfied. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Residents' care plans are completed by the RN and EN. When a resident's condition alters, the RN initiates a review and if required, GP or mental health services consultation.  A physiotherapist, dietitian and wound nurse specialist are available by referral and a podiatrist visits residents regularly. The older persons’ mental health team are readily available as required.  The family members interviewed stated they are kept informed of the resident’s health status and have the opportunity to meet with the GP if required.  Continence products are available and resident files include a urinary continence assessment, bowel management and the continence products that are required are identified.  Adequate dressing supplies are available. Wound management policies and procedures are in place and weights are recorded at least monthly. The wound register currently includes four skin tears, one blister and one abrasion. There were two stage 2 (facility acquired) pressure injuries. Wound dressing charts were being completed however, not all wounds had wound assessments or care plans.  There is a comprehensive range of monitoring forms available for use (including intentional rounding, behavioural management, and repositioning charts) and these had been completed as needed.  The care team and activities staff interviewed were able to describe strategies for de-escalation and the provision of a low stimulus environment where required. |
| 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 service employs a qualified diversional therapist (DT) and two diversional therapy assistants who cover the hours of 1000-1800 seven days per week between them. HCAs incorporate activities into their role for resident needs outside of the DT teams hours. There is an activity room with plentiful resources available.  The DT provides a weekly programme designed to meet the cognitive, physical, intellectual, and emotional needs of the residents in both the dementia care unit and rest home. These include daily walks or exercises, newspaper reading, board games, colouring, movies, and happy hours. There is another quieter lounge in the dementia unit with a pool table. The rest home has an outdoor area and access to a neighbouring local reserve for supervised walks. There is access to safe an outdoor walking pathway and gardens for dementia residents to safely wander.  Indoor physical exercise is provided using an elliptical trainer (electric foot and leg exerciser) which is shared between residents for individual exercises (sighted in use). Residents are able to listen to their music of choice through Bluetooth headphones using iPad, iPhone and iPod set up by staff as seen on the days of audit. Recent activities in the programme have included (but are not limited to) pet therapy, poetry tree, meditation, and sing-alongs. There are also foot spa and pampering sessions.  Consent is gained from rest home residents and their families to join some activities in the dementia unit such as entertainment, church services, board games, guest speakers and outings. There is a large double lounge that can be closed off from the dementia unit (if required) to provide an entertainment area. Community visitors include monthly entertainers, monthly church services and canine friends. The facility has a number of canaries in mobile aviaries which the residents were observed to enjoy on the days of audit. There is one-on-one time spent with residents. Daily contact is made with rest home residents who prefer individual activities and choose which group activities they would like to attend. There are weekly van outings to places of interest or scenic drives.  An activity assessment and a life history are completed within two weeks of admission as sighted in five resident files. A resident DT plan with individualised activities and goals had been developed and evaluated six-monthly for residents who had been at the service six months. Monthly progress notes are maintained. The DT meets with the resident (as appropriate) and relative/EPOA to discuss the activity plan. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Three long-term care plans (one rest home and two dementia care) did not have an evaluation documented six-monthly. The shortfall identified at the certification audit has not been met.  The GP reviews the residents at least three-monthly or earlier if required. Short-term care plans were evaluated regularly for progress against short-term needs. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. This remains an area for improvement as identified in the previous certification audit. |
| 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 | The manager produced detailed evidence of referral to other health and disability services including resident reassessments for hospital and psychogeriatric levels of care. The shortfall in this respect identified at the previous audit has been fully satisfied. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness which expires on 26 June 2022. Fire equipment is checked by an external provider. Facility records evidenced a reactive and preventative maintenance programme. Electrical equipment has been tested and tagged. Hot water temperature is monitored weekly in resident areas and at hot water cylinders with corrective actions documented if outside of the acceptable range.  The corridors are wide enough around the facility with handrails available to promote safe mobility. Residents were observed moving freely around the facility with mobility aids where required. There are areas to wander inside and outside with secure garden areas extending off the dementia unit.  There is sufficient equipment available to staff in all areas that is calibrated annually; next due 18 December 2021.  There are outdoor areas with seating and shade.  The shortfalls related to hot water temperature monitoring and calibration of equipment identified at the last audit have been fully satisfied. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills are scheduled every six months. The orientation programme and annual education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. There is a minimum of one staff available 24/7 with a current first aid/CPR certificate on all shifts, including night shift. Residents were observed in their rooms with their call bell alarms in close proximity.  There are adequate food supplies available in the event of a civil defence emergency and sufficient emergency potable water for three litres per resident per day for three days. The shortfall in this respect identified at the last audit has been fully satisfied. |
| 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 | Springvale Manor has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control nurse with support from the manager. The quality/staff meeting team is the infection control team. Minutes are available for staff (link 1.2.3.6). Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.  The shortfall regarding the annual review of the infection control programme identified at the previous audit has been resolved |
| 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 | Infection surveillance is an integral part of the infection control programme and is described in the Springvale Manor Rest Home infection control manual. Effective monitoring is the responsibility of the infection control coordinator (facility manager). An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review, and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections are documented, collated and any trends analysed. The shortfall in this regard identified at the previous audit has been fully satisfied.  The infection control coordinator shares infection control data, trends and relevant information to the Board and care staff (link 1.2.3.6). Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly. If there is an emergent issue, it is acted upon in a timely manner. On review of the surveillance data the infection rate continues to be very low at the facility and there have been no outbreaks since the last audit.  Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and staff have received both doses of the Pfizer Covid-19 vaccine. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of face masks is required as part of level 2 restrictions. The service has invested in automatic temperature scanners at each entrance for visitors, contactors, and staff to use prior to entry.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP and external quality consultant who both advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the restraint coordinator (facility manager), RN and care staff confirmed their understanding of restraints and enablers. At the time of the audit, there were three residents assessed as requiring restraint but only one resident currently using a restraint and none using enablers (link 1.3.5.2). Staff training is provided around restraint minimisation and management of challenging behaviours. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | The service has a documented quality system. The system has not been fully embedded into practice. The service is small, and the manager and RN monitor the service on a daily basis. The service has a documented quality system which includes the reporting of quality data and outcomes to staff, however this does not occur consistently. The reporting of quality data and outcomes to the monthly quality/staff meeting remains an area for improvement from the previous audit therefore the risk rating has increased to moderate and the timeframe for correction decreased from 90 days to 60. | Not all quality data analysis and outcomes are reported at meetings, this included health and safety information, incidents, accidents, and restraint review information. | Ensure that all quality information is reported to the quality/staff meetings.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | All resident files evidenced an initial assessment and initial care plan completed within 24 hours of admission, however interRAI assessments had not been completed for all resident files. One rest home file and one dementia file had no initial interRAI assessment. Three routine interRAI assessments had not been completed for one rest home and two dementia level clients within the required timeframes. One rest home and two dementia care long-term care plans had not been evaluated six-monthly. Two resident files (one rest home and one dementia care) did not have care plans in place. | (i) Two initial interRAI assessments (one rest home and one dementia care) were not completed within 21 days of admission.  (ii) Three routine interRAI assessments (one rest home and two dementia care) were not competed six monthly or earlier due to health change.  (iii) Three long-term care plans reviewed (one rest home and two dementia care), had not been evaluated six monthly or earlier due to health changes.  (iv) There were no long-term care plans for two residents (one rest home and one dementia care). | (i). Ensure initial interRAI assessments are completed within 21 days of admission.  (ii). Ensure routine interRAI assessments are competed six monthly or earlier for health changes.  (iii). Ensure all long-term care plans are evaluated six monthly or earlier due to health changes.  (iv0. Ensure all residents have long-term care plans in place.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Five resident files were reviewed. Of the care plans available, both dementia care plans reviewed met the residents needs in terms of behaviour management, however, did not document signs and symptoms for chest pain to guide staff in the use of a GTN spray, or the care and change frequency for a supra-pubic catheter. InterRAI assessments identified and triggered risks and required needs and supports to be care planned, however not all care plans had been updated and in two files, long-term care plans had not been commenced. Resident files for three residents assessed as requiring restraint were reviewed and did not include risks and interventions associated with the use of restraint.  The shortfall identified at the certification audit remains. While the rating remains as moderate, the timeframe to address this has been moved from 60 days at the certification audit to 30 days. | (i) One dementia care plan had not been updated to meet the resident’s current needs and supports related to signs and symptoms of chest pain and the care of a supra-pubic catheter.  (ii) There were no long-term care plans in place for two residents (one rest home and one dementia care).  (iii) Risks and interventions associated with the use of restraint were not documented. | (i) Ensure care plans are updated to reflect the resident’s current needs and supports.  (ii) Ensure all residents have a current long-term care plan.  (iii) Ensure all risks and interventions associated with restraint use are documented  30 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | There are wound management policies and procedures in place, however seven of eight current wounds (including two pressure injuries) did not have a wound care plan or assessment. All eight wounds had dressing changes recorded. | Eight wounds reviewed for six dementia level residents did not have a wound assessment or wound care plan. | Ensure all wounds are assessed and a plan of care documented as per policy.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Previous written evaluations sighted, documents the resident’s progress against identified goals and states the EPOA/relative involved in the evaluation, however these documents had not been dated within the last six months. | There was no current six-monthly written evaluation for one rest home and two dementia long-term care plans. | Ensure care plans are evaluated at least six-monthly for progress towards meeting the desired goals.  90 days |

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

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

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

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

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| No data to display |

End of the report.