

Fergusson House Restcare Limited - Fergusson House

Introduction

This report records the results of a Certification Audit; Partial 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 HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Fergusson House Restcare Limited

Premises audited: Fergusson House

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

Dates of audit: Start date: 15 February 2022 End date: 16 February 2022

Proposed changes to current services (if any): 1. Change of service configuration to include up to five hospital level care beds.
2. Assessment of suitability for a new premise- one retirement village unit for delivery of rest home level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 39



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

Fergusson House provides rest home level care for up to 44 residents. Short stay/respice care can be provided subject to bed availability. An interim nurse manager is appointed to oversee day to day operations for a fixed term and governance is provided by a small group of directors.

This is the first certification audit for Fergusson House, since the service was purchased by Fergusson House Restcare Limited in March 2021. The audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, one director, staff, and a general practitioner (GP). The GP, residents and families spoke positively about the care provided.

The most significant change since the change of ownership is the appointment of a new nurse manager who has been temporarily replaced by an interim nurse manager.

The operators submitted a request to the Ministry of Health in August 2021 to reconfigure the current scope from rest home level care to a limited number of hospital level care rooms. The operator chose not to proceed with assessing for reconfiguration to hospital level care on day one of the audit. A second request was submitted on 11 February 2022 to reconfigure a retirement village unit as suitable for rest home level care. Therefore a partial provisional audit specific to parts of these standards was undertaken.

There were eleven areas requiring improvement identified as a result of the certification audit. These relate to the obtaining and recording of informed consent, the timeliness of assessment, planning and review of resident cares, medication management systems, the skills and experience of the interim nurse manager, aspects of the quality and risk system, reporting adverse events, staffing levels, consent for the use of enablers and implementation of the infection prevention and control programme.

An additional five improvements were identified in the partial provisional audit. These were specific to the environment.

Consumer rights

Fergusson Home incorporates the Code of Health and Disability Services Consumers' Rights (the Code) into its policies and procedures, and into everyday practice. Residents are treated with dignity and respect. Privacy is provided and family contact is supported. Cultural and spiritual values and beliefs are identified and respected. Māori residents are acknowledged and provided time and opportunity to practice their cultural values. Staff are educated on and aware of discriminatory behaviour. Residents understand the principles of informed consent. Communication between the service and the resident's family is an effective two-way process. A complaints register is maintained and any complaints received are resolved promptly and effectively.

Organisational management

An annual business plan describes the scope, direction, goals, values and mission statement of the organisation. A business continuity plan is in place as required by the DHB. Designated staff are monitoring all aspects of the services provided. There is an interim nurse manager appointed in December 2021 is on an interim fixed term until July 2022.

The quality and risk management system collects quality data, and identifies trends. Staff are involved, and feedback is sought from residents and families. Apart from one known incident, adverse events related to residents are documented, and actions are taken to prevent recurrence.

Actual and potential risks, including health and safety risks, are identified and mitigated.

There are established systems for the appointment, orientation and management of staff and a systematic approach for identifying and delivering staff education. This supports safe service delivery and includes regular individual performance review.

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

Continuum of service delivery

Entry to the service follows appropriate assessments and referrals. The provision of services is delivered by care staff with knowledge and skills. All residents have assessments and goal setting meetings, which inform the care -plan development. Interventions are suitable to meet the resident's goals and evaluation of care occurs six monthly. Referrals to other service providers are made if required. Transfer and/or exit from the service is co-ordinated and relevant documents are completed. Residents and family were satisfied with the provision of care.

The activity programme is varied and provides residents with individual and group activities.

Medicines are safely managed and administered by medication competent staff.

Food is prepared on site and the service caters for individual resident needs and preferences. The menu is approved by a registered dietician. There is a current food plan. Residents expressed satisfaction with the meals.

Safe and appropriate environment

The facility meets the needs of rest home level care residents. The building and chattels are being maintained as safe. Specific items of electrical equipment are tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and safe for residents' use.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Sufficient supplies of products required in the event of an emergency or pandemic are on site. Chemicals, soiled linen and equipment are safely stored. There has been a change to cleaning and laundry processes.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells.

The retirement unit is suitable for rest home level care contingent upon implementation of the corrective actions prior to occupancy.

Restraint minimisation and safe practice

The home has a philosophy and practice of no restraint. There were no restraints in use. On the days of audit, a number of enablers such as bed levers were in use to promote independence and to keep residents safe. Policy meets the requirements if a restraint is required and staff education is ongoing.

Infection prevention and control

The infection control programme meets the needs of the organisation and undergoes annual review. Infection control policies reflect best practice. Staff are educated on the principles of infection prevention and control. Infection data is collated and analysed monthly. The service has prepared and is managing risks related to Covid 19.

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) |
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| Standards | 0 | 33 | 0 | 4 | 8 | 0 | 0 |
| Criteria | 0 | 76 | 0 | 9 | 7 | 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) |
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| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | <p>FA</p> | <p>Fergusson Home has current policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Staff understood the requirements of the Code and were able to give examples of how they incorporated the Code into their interactions with the residents. Staff were observed demonstrating respectful communication, encouraging independence, and maintaining the dignity and privacy of the residents. Training on the Code is included in staff orientation and as part of on-going in-service education. Residents and family members were happy with the care and support provided.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | <p>PA Moderate</p> | <p>Residents and their family are provided with information about the service provided on admission. This includes the mission statement, residents' responsibilities and complaint options. A signed admission agreement, meeting all requirements, was sighted in all resident files sampled. Staff interviewed discussed the principles of informed consent and gave examples of how they implement them in their daily</p> |

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| | | <p>practice. Residents and relatives interviewed confirmed they understood verbal information provided to them, and that it assisted them to make informed decisions. Some files sampled held the residents signed advance directives.</p> <p>An improvement is required regarding gaining written consents.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>Information regarding the availability of the advocacy services is included in the information pack provided to residents and family on admission. The complaints process also includes the residents' right to advocacy. Interviews with residents and family confirmed that they are aware of their right to advocacy.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents and relatives confirmed visiting hours meet their requirements. Visitors were observed coming and going during the audit, in accordance with the Covid-19 regulations. Residents have access to telephones to maintain links with family and community groups. Care plans sampled demonstrated that residents were encouraged to maintain community links, however residents and staff interviewed confirmed that resident visits into the community were currently restricted due to Covid 19 regulations.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints policy and associated forms meet the requirements of this standard and Right 10 of the Code. Information on the complaint process is provided to residents and family members on admission. Information and forms are readily accessible and on display. Family members said they felt comfortable and would not hesitate to raise a concern if they had one. The nurse manager is responsible for complaints management and follow up. Staff confirmed a sound understanding of the complaint process and what actions are required of them.</p> <p>Five complaints had been received since the last audit. Two involved the local office of Nationwide Health and Disability Advocacy Service. One complaint had not been recorded in the register and this was</p> |

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| | | <p>remedied during the audit. Documents and interview with the nurse manager confirmed formal complaints are acknowledged in a timely manner, investigated and actions taken that achieved resolution with the parties involved.</p> <p>There have been no known complaints to the Office of the Health and Disability Commissioner (HDC) since the previous audit in March 2021.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>The Code is displayed throughout the facility. On admission residents are given an information pack which contains a brochure explaining the Nationwide Health and Disability Advocacy Service, the Code and the complaints process. It was confirmed that this information is discussed with the resident and their family.</p> <p>Feedback forms are provided to the resident and family on admission and are also available throughout the facility. Residents and family interviewed stated they would feel comfortable raising a complaint or issue with staff and/or management.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>There are current policies that address the components of this standard. Staff described how they ensure that residents are treated with respect, dignity and provided privacy and independence to the residents. They were aware of the signs of abuse and neglect and discussed their role if they became suspicious of abuse or neglect occurring.</p> <p>Residents and family members confirmed that care was received in a manner that had regard for their dignity, privacy, sexuality, spirituality and choices. Clinical files sampled care plans included documentation relating to the resident's abilities and included strategies to maximise their independence. Cultural, religious, social needs, values, and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Observation during the audit confirmed that residents were treated in a manner that had regard for their privacy, dignity and cultural and spiritual values.</p> |

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| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p> | <p>FA</p> | <p>There is a current Māori health plan that supports the service to meet the needs of the residents who identify as Māori. Local services and groups are available to provide additional cultural support and resources if required.</p> <p>Māori residents and their whānau confirmed that staff acknowledge and respect their cultural needs. They also acknowledged Māori staff members as providing a specific spiritual connection that they valued. During the audit staff were observed to demonstrate a knowledge and respect of Māori values.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Current policies and procedures address the components of this standard. Staff described how they ensure that residents are treated with respect, dignity and provided privacy and independence to the residents. They were aware of the signs of abuse and neglect and discussed their role if they became suspicious of abuse or neglect occurring.</p> <p>Residents and family members confirmed that care was received in a manner that had regard for their dignity, privacy, sexuality, spirituality and choices. Care plans sampled included documentation relating to the resident's abilities and included strategies to maximise their independence. Cultural, religious, social needs, values, and beliefs had been identified, documented and incorporated into the care plans. Observations during the audit confirmed that residents were treated in a manner that had regard for their privacy, dignity, cultural and spiritual values.</p> |

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| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>Staff orientation and on-going in-service education is provided and includes discrimination, coercion and harassment. Staff demonstrated an understanding of what discrimination is and of their professional boundaries. Employment contracts identify professional boundaries regarding harassment and exploitation.</p> <p>Residents and family spoke positively about the care and support provided by the staff and the service. There was no evidence of discrimination observed during the audit. The general practitioner (GP) stated that no evidence of discrimination had been observed.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>Staff and resident interviews, clinical documents and observation of care provision confirmed that resident care was being delivered safely by experienced care staff.</p> <p>Health care assistants have completed a formal training programme which is implemented in the daily provision of care to residents. The GP attends the service regularly to review residents. During interview the GP confirmed that there is an efficient communication system in place to ensure all residents are seen as soon as a need arises. The service and pharmacy network effectively to ensure medications are available in a timely manner.</p> <p>Policies and procedures align with the Health and Disability Services Standards however these are not fully implemented. (Refer to 1.2.3.3).</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>The manager stated that the resident's family are notified of incidents involving a resident. Staff interviewed were aware of the principles of open disclosure.</p> <p>Family members confirmed they were happy with the level of communication and were advised of incidents involving the resident. They also stated they felt comfortable to raise questions and request more information about the incident as desired. Clinical records sampled confirmed that where incidents involve residents, family are notified in a timely manner, however not all incidents are reported</p> |

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| | | <p>(refer to 1.2.4.4).</p> <p>At the time of the audit there were no resident's requiring an interpreter, however staff advised that when interpreter services are required, they have access to the district health board (DHB) interpreter, or alternatively the interpreter telephone line.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The business plan is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. This document includes five goals with time framed objectives and refers to the quality and risk plans. Interview with one of the directors and monthly operational reports submitted by the nurse manager verified methods for informing the governing body about organisational performance and service delivery to residents. One of the directors visits the site monthly.</p> <p>A new nurse manager was appointed shortly after the service changed hands and this person is now on long term leave. The interim nurse manager is a registered nurse with a current practicing certificate and is on a fixed term employment contract until July 2022. Both changes in management were notified to the Ministry of Health (MOH) and the DHB. There is a non-conformity related to the skills and experience of the interim nurse manager in standard 1.2.2.</p> <p>The company holds contracts with Lakes DHB, for rest home level care and respite services. The facility has a maximum capacity of 44 beds and on the days of audit 39 beds were occupied. One resident was there for respite/short stay care and one resident nearing the age of 65 years was receiving long term care under the Accident Compensation Corporation (ACC) scheme.</p> <p>Partial Provisional audit</p> <p>Assessment to reconfigure up to five rest home beds to hospital level care, submitted to the MOH in August 2021, did not proceed at the request of the director on day one of the audit.</p> <p>A second request submitted on 11 February 2022 to reconfigure a</p> |

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| | | <p>retirement village dwelling under an occupation right agreement (ORA) to rest home level care was taken into consideration during the audit. The former occupants of the dwelling- a couple, had recently been assessed as requiring rest home care had already transferred to a studio type rest home room two weeks before the audit. The couple interviewed want to return to the apartment they had been in. This is located under the same roofline as the rest home and is two doors down from the room they had moved to. Installation of call bells that link with the rest home and other actions need to occur before this is possible (refer to required improvements in standard 4). The director advised that the ORA between the couple and the company will be terminated and settled to simplify the process before the couple transfer back to their former space.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>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.</p> | <p>PA Moderate</p> | <p>The existing nurse manager is on maternity leave until July 2022. An interim nurse manager (NM) was appointed for a fixed term in December 2021 to cover. Review of this person's personnel records and interviews confirmed this person does not have previous experience in managing an aged care service and although a two month handover had occurred, did not appear to fully understand and perform all aspects of the role.</p> <p>The interim NM is a registered nurse (RN), initially employed as a casual RN in August 2021. There are two employment agreements in place for this person, one for the fixed term and the other for a clinical manager. This person is developing the staff roster, recruitment, overseeing staff education, the quality and risk system, clinical care, holds the position of infection control coordinator, restraint coordinator and is responsible for day to day management of service delivery. They have also been backfilling shifts to cover staff absences. Their personnel record contains evidence of positions held in aged care environments as an RN (casual and full time) a clinical coordinator for an aged care facility in 2008 and a coordinator for a home and community services agency in the past 15 years. Weekly support to the NM specific to people management skills is being provided by a contracted registered psychologist. The owner/director stated they will now be on site daily to support the nurse manager and ensure safe</p> |

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| | | <p>and effective service delivery.</p> <p>Partial Provisional Audit</p> <p>The couple who transferred from their independent living unit to a rest home studio reported no issues with the care and services they have received since the beginning of February. The ongoing provision of safe and timely rest home level care and services was assessed as not likely to be impacted by a return to their previous unit which is located two doors down the corridor from where they are currently residing. This is contingent on termination of the ORA and completion of the actions identified in part four of this report.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>PA Moderate</p> | <p>The company have developed a new set of policies and procedures, quality and risk plans. This includes a fully documented risk management system which describes processes for the identification, and management of risks according to their likely occurrence, severity and consequence. The systems used prior to change of ownership for monitoring service delivery such as internal audits, consumer satisfaction surveys, adverse event reporting and management of health and safety are still in place. Stage one of this audit, which assessed the content of policies and procedures, identified eight areas requiring improvement. These had not been addressed before the audit took place. Staff could not locate the current policy set and there was no evidence staff had been introduced or educated about their contents.</p> <p>Already established quality and risk processes were being followed which to some extent has maintained the integrity of the system. Regular internal audits were identifying gaps in documentation and processes, which led to immediate remedial actions. The outcomes of service monitoring were being shared with staff at their three monthly meetings prior to January 2022 but were not shared according to the minutes of the most recent staff meeting. Monthly collation and analysis of incidents and accidents was identifying trends and this is graphed. Health and safety processes are in place to good effect. The nominated health and safety coordinator and team meeting minutes confirm attention to identifying resident, staff and environmental risks</p> |

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| | | <p>and record actions taken to preventing, minimising or eliminating causes.</p> <p>The previous operators had a dedicated quality team who managed the system, conducted audits and benchmarked results across their own facilities. This is no longer the case. The quality and risk system requires review and amending to ensure it is realistic for the size and scope of the service.</p> <p>Apart from the health and safety team processes, actions taken to rectify service areas identified as requiring improvement, were not being reliably reported and documented.</p> <p>Improvements are required in 1.2.3.1, 1.2.3.3 and 1.2.3.8. Although these non-conformities are individually rated as low risk, the combined overall risk rating for this standard is moderate.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>PA Low</p> | <p>There is an established process for the reporting and management of adverse events. Staff document adverse events on accident/incident forms. A sample of forms from 2021 -2022 were consistent in clearly describing and detailing the incident and recording who had been notified. The most common event is falls. Each unwitnessed fall event had attached records of post fall neurological observations. Accidents and incidents are overseen by the health and safety representative and the nurse manager. All events are collated into the type and time of event which is used to analyse month by month trends. A monthly summary page is also produced which identifies the resident and type of incident, and a narrative account of actions taken to mitigate or prevent recurrence. Information about incidents is shared at three monthly staff meetings and graphed data is displayed in the staff room.</p> <p>A section 31 notification about a facility acquired stage three pressure injury was submitted to the Ministry of Health on 08 February 2022.</p> <p>An improvement is identified in 1.2.4.3 about a one off event that was not reported.</p> |

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| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Staff management policies and processes are based on known employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. Copies of practising certificates for the registered health practitioners providing services at the home are on file. A sample of staff records reviewed, confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis with in-service training sessions occurring at least monthly. There was documented evidence that competency assessments for all care staff and registered nurses were being completed at appropriate intervals. Examples of competencies assessed are infection prevention and control including Covid 19 awareness, handwashing, emergency and fire procedures, health and safety, safe transfers and use of hoist equipment, insulin therapy and medicines competency for the RNs and five health care assistants (HCAs) who administer medicines. Sufficient training and educational opportunities are provided to meet the requirements of the provider's agreement with the DHB. A majority of the 14 care assistants have achieved the level four national certificate in health and wellbeing. The staff records sampled demonstrated attendance at ongoing training and completion of annual performance appraisals.</p> <p>The nurse manager and one other registered nurse are trained and are maintaining their annual competency requirements to undertake interRAI assessments. A third RN, who was in training, has tendered their resignation. Due to staff changes and Covid 19 interruptions, only five staff have a current first aid certificate. This includes two RNs, the activities coordinator and two care assistants. This is addressed in standard 1.2.8.</p> <p>Partial Provisional</p> |
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| | | <p>The same experienced and trained staff, as described above, are already providing rest home services to the residents. This will not change when they to return to their previous apartment.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>PA Moderate</p> | <p>The service employs 31 staff. The previous six RNs employed will be reduced to two RNs after the 23 February due to resignations. Recruitment for more RNs is underway with interviews scheduled. Fourteen other care staff including two ENs are employed. Weekly rosters are developed and published a fortnight a head of time. Rosters sampled across three months from December 2021 to February 2022, show five care staff on site for a range of hours between 7am and 3.30 pm The nurse manager is on site 8am to 4.30pm and another RN 7am to 3.30 pm Monday to Friday. Both RNs share the after-hours on call. Three HCAs, which includes one nominated as senior HCA, cover the afternoon shift and there are two staff at night. One of these was an RN or an EN.</p> <p>The formulas used to determining safe staffing levels are based on the 2005 Indicators for Safe Aged-care and do not take into account current resident needs and acuity.</p> <p>There have been reported gaps in the roster due to the number of staff resignations since May 2021 (seven HCAs and three RNS). An improvement related to the availability of staff is required.</p> <p>Staff from all shifts and different disciplines described the recent changes in staff allocation and tasks as negatively impacting a smooth workflow, creating stress and causing some delays in attending to resident cares. Staff were observed to be working cooperatively and there were examples of them seeking solutions to manage the workload. Call bells were observed being attended to in a timely manner. Two of eight residents said there needed to be more staffing, particularly in the evenings and at night. Family members expressed no concerns. The impact of changes made to the roster in September require review.</p> <p>Review of the rosters revealed there is not always a staff member on duty with a current first aid certificate.</p> |

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| | | <p>Partial Provisional</p> <p>The evidence, findings and corrective actions for this criterion apply to the request for reconfiguring the ORA apartment for rest home level care.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>Residents' files are paper based, and medication files are electronic. Paper based files are kept in a filing cabinet in the staff office. Files are not visible nor accessible to the public. All clinical records sampled were legible and included the name and designation of the writer, the residents name and unique identifier number and met current documentation standards. Health care assistants document in the record each shift detailing all care provided to the resident. Registered nurses document care assessments and care provision as it is provided. Stable residents have a weekly entry in the clinical record by a registered nurse. Records sampled were integrated and included documentation pertaining to nursing, medical, allied health and contained transfer and discharge documents when the resident has been in another service. Archived records are stored securely onsite and can be accessed in a timely manner. The electronic medication management programme is password protected, and users have restrictions associated with their username to ensure they are only able to access residents in their care and make entries on the record as per their scope of practice.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>Needs Assessment and Service Coordination (NASC) assessments are completed prior to the resident's entry to the service. If required, the service liaises with the needs assessors and other relevant agencies prior to the resident's admission to ascertain the resident's care requirements.</p> <p>Residents and family members stated they were satisfied with the admission process and that it had been completed in a timely manner. Residents' files sampled contained completed demographic detail, assessments, and signed admission agreements which aligned with the requirements of the Age-Related Residential Care Services</p> |

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| | | Agreement (ARRC). |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Residents may be transferred from the service acutely or as the result of a planned discharge. In the instance of an acute transfer out of the facility the resident's family are notified and may choose to transfer the resident to the public hospital themselves if it is considered safe by the GP and/or the RN. If required, the resident is transferred to the public hospital via ambulance. The national yellow envelope documentation system is used and accompanies the resident. This was confirmed during discussion with the manager and sighting clinical records.</p> <p>A planned discharge occurs when the resident is moving permanently to another residence. Communication occurs between Fergusson Home, the receiving service, the GP, the NASC service and the resident and family. A copy of relevant information accompanies the resident as verified by clinical record.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | PA Moderate | <p>There is a current medication management policy which identifies all aspects of medicine management and reflects relevant legislation and guidelines.</p> <p>An electronic medication management system is used. Medication charts sampled confirmed that the prescribing and administration of medications reflect legislation and best practice guidelines. Resident allergies and sensitivities were documented on the medication chart and reflected the notations in the clinical record. All charts had been reviewed by the GP within the past three months. As required (PRN) medications prescribed had an indication for use and a daily maximum dose, and the effectiveness of the medication administered had been documented in charts sampled.</p> <p>A pharmacy pre-packaged medication system is used, and medication is checked by the RN on delivery to the facility. No stock medications are held on site. The pharmacy collects expired or unwanted medication. No standing orders are used at the facility and vaccines are not held on site. All eye drops and ointments had documented</p> |

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| | | <p>opening dates.</p> <p>The service provides annual medication competency education to RN's and some HCA's. Only medication competent HCA's administer medication. Current medication competencies were sighted in staff files reviewed.</p> <p>A medication was round was observed and verified that staff administering medication demonstrated knowledge and understanding of the role and responsibility related to safe medication administration.</p> <p>There was one resident self-administering medication on the day of the audit. The resident had a current competency assessment, which was signed by the GP. The medication was stored in a safe location in the resident's room. The resident was interviewed and discussed the medication being taken, its indications and the frequency of administration.</p> <p>The medication refrigerator temperatures were recorded and met the recommended range; however, the temperature of the medication room was in excess of the recommended room temperature range.</p> <p>Controlled medications were stored as per legal requirements, and a controlled medication register is used, however weekly stocktakes and six-monthly quantity stock accounts of controlled medications were inconsistently completed.</p> <p>Partial Provisional</p> <p>Safe and efficient medicines management to the residents concerned is already occurring. This is not likely to be impacted when they return to their previous apartment.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>All meals are prepared on site. There is a current food control plan, expiring June 2022. A summer and winter menu are used, with menu plans having a six-weekly rotation. The menu had been reviewed by a registered dietitian and was approved until February 2023. The kitchen supervisor has 45 years of industry experience.</p> <p>A cleaning schedule was sighted and completed as per requirements. On the day of the audit the kitchen was clean and tidy. Temperatures</p> |

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| | | <p>of fridges and the freezer are monitored and recorded daily, as is the temperature of food served to residents, this was verified by records sighted.</p> <p>On the day of the audit, food was stored in fridges, a freezer, and a storeroom. No decanted food was sighted. Food supplies sighted in the storeroom and freezer were labelled and had an opened date where appropriate. All prepared food, for example sandwiches were stored in a fridge covered and dated. In preparation for potential food supply chain problems related to Covid 19, the service held approximately five to six days of supplies that could be utilised to feed the residents.</p> <p>A nutritional assessment is undertaken for each resident on admission by a RN to identify the residents' dietary requirements and preferences. A copy of the information is provided to the kitchen staff. The resident's dietary needs are reviewed six monthly, and more frequently if indicated. Updates are given to the kitchen staff. Diets are modified as needed, and specific dietary needs can be catered for, for example gluten intolerance. Refer to 1.2.8 for finding related to untrained staff assisting with resident feeding.</p> <p>Residents and families interviewed stated that they were satisfied with the meals provided.</p> <p>Partial Provisional</p> <p>The residents concerned are attending meals in the dining room. Their nutritional needs are being addressed. It is not likely this will be impacted when they return to their previous apartment.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p> | <p>FA</p> | <p>A resident will be declined entry if the care required is not within the scope of the service or if a bed is not available. The reasons for declining entry to the service are recorded and communicated to potential residents and their family. Anyone declined entry is referred to the referring agency for appropriate placement and advice. A folder was sighted verifying that the entry and decline processes were implemented.</p> |

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| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>FA</p> | <p>The initial nursing assessments includes dietary requirements, a falls risk and continence assessment. Information is gathered following interviews with the resident and their family, and other relevant sources for example InterRAI assessments, and hospital discharge letters.</p> <p>Clinical files sampled confirmed that InterRAI assessments were completed by an RN within the required timeframes. There was evidence of other assessments being made, for example wound assessments and pressure area assessments, however there was insufficient evidence to confirm that these assessments were always completed in a timely manner (refer to 1.3.3.3)</p> <p>Resident centred goals were documented and reviewed six monthly, or as required. Residents and family members confirmed involvement with the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>Clinical files sampled verified that the initial assessment and initial care- plan were completed within required timeframes. InterRAI assessments had been completed within three weeks of admission and informed the development of the long-term care plans.</p> <p>Individualised long-term care plans with interventions suitable to support the resident's needs and goals were sighted in all files sampled. Service integration was demonstrated in the clinical records which held activities reports, laboratory reports, and medical and allied health professionals' documentation.</p> <p>Short-term care plans were sighted in the residents' clinical records and addressed acute, short-term problems. The care-plan was signed off when the problem had resolved.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Interventions were documented in resident's care-plans that reflected the resident's health status and desired goals. Staff confirmed they were familiar with the interventions required for each resident, and that they had access to the supplies, equipment (refer 1.3.3) and products</p> |

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| | | <p>required to provide the interventions. This was confirmed by observation during the audit.</p> <p>Evidence of GP three monthly reviews and care recommendations were sighted in the clinical record. The GP was interviewed and stated that care recommendations were implemented in a timely manner by staff.</p> <p>Interviews with residents and families confirmed that care and treatment met the residents' expectations.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The residents' activities programme is implemented by an activities co-ordinator with fifteen years' experience. Activities for the residents are provided five days a week, 8.00am to 3.30pm. Residents have access to television, movies and reading material, including a library in the weekend. The activities programme is displayed throughout the facility and an individual copy is provided to each resident. The activities co-ordinator will remind residents individually of a planned activity that will be of interest to the resident if required.</p> <p>The programme provides variety in the content and includes exercise, discussion of current events and interactive games, for example Housie. Spiritual needs are also catered for, for example virtual church services. One to one activity occurs for residents who choose to stay in their room, and includes for example, reading, verbal discussion and jigsaws.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated each shift and reported at handover and in the progress notes. If a health care assistant notices a change in a resident's condition it is reported to the registered nurse.</p> <p>Monthly vital signs and weight monitoring was sighted in records sampled.</p> <p>Resident files sampled confirmed that six monthly review of the care-plan occurs. Modification to interventions are made following the interRAI re-assessment, information gathered during discussion with the resident and family, and in conjunction with observation of the</p> |

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| | | resident. Although revised interventions are implemented to meet the resident's needs, there was insufficient evidence to confirm that the residents care is escalated in a timely manner (refer 1.3.3.3). |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>The service facilitates access to other health and disability services, for example physiotherapist, podiatrist or ear nurse. Where needed, the GP will refer a resident for specialist care. Documentation of referrals were sighted in resident files. Communication records in the residents' files confirmed that family are notified of, and kept informed of the referral process, and this was verified during interviews with residents and their family.</p> <p>When a resident's condition requires increased monitoring and care, referral to other agencies is not always completed in a timely manner (refer to 1.3.3.3).</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals are provided with support and education from the chemical supplier about the safe use of chemicals. Chemical safety data is on display where the chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Signed consents for trade waste were sighted and all domestic waste is being collected regularly without incident. Protective clothing and equipment (PPE) is provided and staff were observed to be using this. Additional stores of PPE are on site in the event of an outbreak. Sharps containers are available and oxygen cylinders/equipment is safety stored. The facility has one sluice room located inside the laundry area which is accessible by keypad entry. The sluice room was clean and contained all necessary equipment for effective sanitising and protection of staff during sluicing procedures. There have been no known adverse events related to waste and hazardous substances.</p> |

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| | | <p>Partial Provisional</p> <p>Current systems for management of waste and hazardous substances are effective. The distance and location of the ORA apartment and waste created by two rest home level care residents will not significantly impact efficient and safe methods for waste disposal.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>PA Low</p> | <p>The building warrant of fitness is current and expires on 12 October 2022.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for purpose and maintained. Tasks scheduled in the building maintenance programme are carried out at regular intervals by maintenance staff who are onsite three days a week. Specific items of electrical equipment are tested as required, for example residents who want electric blankets are advised these must be tested as safe before bringing them into the home. The buildings electrical systems are fitted with residual current devices (RCD) which cut the power when electrical faults are detected. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, on-site visual inspections and interview with maintenance staff. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident group and setting. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. They said requests are appropriately actioned and that they are happy with the environment. This was confirmed in the maintenance request documents. The hazard management system ensures any hazards are identified and managed accordingly. A hazard register is maintained</p> <p>Partial Provisional</p> <p>The ORA apartment is in good condition, suitable for rest home level care and is included as part of the building warrant of fitness. This is located within the same building framework as the rest home and is easily accessed internally. The electricity had been cut off and needs to be reconnected. Cooking appliances need to be disconnected or</p> |

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| | | removed, and final safety checks of the environment made before residents return. |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p> | FA | <p>All but three of the current 39 rest home bedrooms have accessible ensuite bathroom and toilet amenities. Although not all bathrooms can accommodate a hoist. Two residents share the bathroom and toilet located between their bedrooms. One resident is the sole user of a bathroom, shower and toilet located opposite their bedroom. All bedrooms have a washbasin with hot and cold running water. Hot water temperature is regulated by tempering valves and monitoring of the temperatures at the tap is carried out monthly. The temperature records sighted show hot water is delivered within a safe range of temperatures. Residents interviewed were very happy with the provision, cleanliness of and access to ablution areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Partial Provisional</p> <p>The toilet, shower and bathroom in the ORA apartment is fully accessible and fitted with handrails. The residents concerned require minimal assistance with their day to day hygiene. Staff confirmed that temperature checking of hot water in the apartment will be included in the monthly schedule.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>There are currently 39 rest home bedrooms and all but one were occupied by a single resident. The couple who moved from their ORA apartment are sharing a studio room. The addition of the ORA apartment for rest home care will increase the number of rooms available to 40. The maximum capacity will stay at 44 residents. Inspection revealed that each room provides adequate personal space to allow residents and staff to move around within their bedrooms safely. Rooms were personalised with furnishings, photos and other items displayed. Each room is unique in its size and shape and can easily accommodate a bed, seating and other furniture. There are</p> |

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| | | <p>additional rooms and spaces for storage of mobility aids, wheelchairs and mobility scooters. There is one swing hoist on site, which was being used for safe transfers of two residents. Family and residents expressed satisfaction with their bedrooms.</p> <p>Partial Provisional</p> <p>The ORA apartment has a spacious separate bedroom and plenty of space for residents and staff to move around safely. The residents are already familiar with these surroundings and desire to return. The only mobility aid in use at the time of audit was a walker for one of the residents. No lifting or transfer equipment is required, but this would be easily accommodated in the apartment.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>The home has one spacious and welcoming communal lounge which is centrally located and within easy walking distance from all residents' rooms. A large separate dining room is located opposite the lounge. This is furnished with sufficient and suitable tables and chairs for the residents who chose to eat in the dining room. The space easily accommodates wheelchairs if required and storage of mobility walkers during mealtimes. These areas could easily accommodate the hoist if required. All residents are served breakfast on trays in their bedrooms. The lounge is used for activities and has varied seating configurations if someone doesn't want to participate in the programme. Residents were seen to be accessing their bedrooms and other smaller spaces for rest, visiting and privacy when they wanted. The furniture throughout the home is in good condition and appropriate for residents' needs.</p> <p>Partial Provisional</p> <p>The residents who previously occupied the ORA apartment were observed to be independently attending meals and activities in the communal areas. The apartment is two rooms further down the corridor from the studio room they are currently occupying. The distance between the lounge and dining areas to the apartment is easily walked on a flat level and under the same roof line. This is not an impediment for independently mobile rest home level care people.</p> |

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| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>PA Low</p> | <p>Care staff have always been tasked with laundry duties over a 24 hour period. Recent changes led to some cleaning hours being allocated to laundry duties Monday to Friday. A corrective action is issued in criterion 1.2.8.1 to review the workflows for care staff and the cleaning and laundry staff.</p> <p>Staff interviewed about laundry demonstrated good knowledge of laundry processes, dirty/clean flow and handling of soiled linen. All staff have attended training in the safe handling of the chemicals on site and in health and safety matters, as confirmed by review of personnel files and interviews with staff. Bulk chemicals are stored in a lockable room when not in use and are decanted into clearly labelled containers.</p> <p>The current methods and frequency for cleaning and laundry services needs to be regularly monitored for effectiveness and take into account the additional demand for cleaning in the previous ORA apartment. An internal audit on 14 January 2022 did not identify any major concerns.</p> <p>There were no documented complaints from residents or family about cleaning and laundry. Two residents commented on delays in getting their clothes back and said their named clothes had been found in other resident's rooms. Policy states that laundry will be returned to residents within 36 hours. The environment was observed to be clean on the days of audit.</p> <p>Partial provisional</p> <p>Reconfiguring the ORA apartment to rest home care will place additional demand on cleaning services. This needs to be considered by cleaning staff and management before the two residents return to the apartment. Laundry services for the couple have been provided to their satisfaction within the past two weeks.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p> | <p>PA Moderate</p> | <p>Policies and guidelines for emergency planning, preparation and response are specific to the facility and are known to staff. Disaster and civil defence planning guides direct the organisation in their</p> |

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| <p>emergency and security situations.</p> | <p>preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. All staff interviewed confirmed they had attended training in emergency management. This and competency assessments for emergency procedures was verified in staff training records.</p> <p>A current fire evacuation scheme is approved. It is not known if the scheme includes the ORA apartment which rest home residents wish to return to. Trial evacuations take place every six months and a copy of the finding from each drill is sent to the local fire service. The most recent drill occurred on 28 October 2021 and is scheduled to occur again in 22 February 2022. The time taken for evacuation is recorded and there have been no issues or risks identified. The most vulnerable or mobility impaired residents are listed on the fire board and are assisted first. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use by 44 residents and staff in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. Two thousand litres of water is stored in an outside tank and there is a generator on site. The petrol powered generator and emergency lighting is regularly tested.</p> <p>The call bell system was functional on audit days and staff were observed to attend to these in a timely manner. Residents and families were happy with staff responses to call bells at all times of the day and night.</p> <p>Staff lock the external doors and windows each night for security purposes.</p> <p>Partial Provisional</p> <p>Quotes have been obtained for the installation of three call bell points in the apartment. It is not known if the current fire evacuation scheme includes the ORA apartment. This needs to be reviewed by Fire and Emergency Services New Zealand. Future trial fire evacuations will need to include whoever is living in the apartment. Systems for alerting these residents to fire or the need for an emergency evacuation need</p> |
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| | | to be tested. Corrective actions apply to criterion 1.4.7.3, 1.4.7.5 and 1.4.7.6. |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>Residents' rooms and communal areas are heated and ventilated appropriately. All rooms have sufficiently sized windows that open to the outside and allow plenty of natural light and fresh air. Heating is provided by a combination of gas boiler and panel heaters. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There is a designated area for smoking well away from the building in the event that a resident who smokes is admitted.</p> <p>Partial Provisional</p> <p>The residents who used to live in the apartment said it was very easy and quick to heat and that windows in every room allowed good air flow and ventilation. In the event that the ORA is not terminated, and/or the residents become fully subsidized, the owner/operator and residents need to amend the system for paying use of electricity. Currently the apartment is on a separate power meter.</p> |
| <p>Standard 3.1: Infection control management</p> <p>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.</p> | FA | <p>The Infection Prevention and Control (IPC) programme is reviewed annually and is appropriate for the size and complexity of the service. Staff are made aware of new infections through daily handovers at each shift, and via the resident's progress notes and short-term care-plan. Hand sanitisers and gels are available for staff, residents, and visitors to use. There are processes in place to isolate infectious residents when required. The GP stated that the service practised effective infection prevention and control procedures.</p> <p>The IPC nurse is responsible for the IPC programme; however, this position was vacant at the time of the audit (refer to 3.2.1). There is a position description for the IPC nurse who reports through the manager to the owner of the service.</p> <p>The service has a Covid 19 policy and related procedures. Doors are locked and visitors must scan in using the Covid 19 app and show their</p> |

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| | | vaccine pass prior to entering the building. The manager advised that external infection control specialists had visited the facility in order to ensure the service was Covid 19 prepared. The GP confirmed that appropriate policies and procedures were in place and that the service was Covid 19 prepared. Supplies of Personal protective equipment (PPE) was sighted during the audit. |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | <p>PA Moderate</p> | <p>Surveillance data, education records and interviews with staff confirmed that the Infection Prevention and Control programme had been implemented in 2021. Staff demonstrated an understanding of the principles of the infection prevention and control programme. The service has a supply of personal protective equipment (PPE) should an infection outbreak occur.</p> <p>A corrective action is required in 3.2.1.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>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.</p> | <p>FA</p> | <p>Fergusson Home has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff demonstrated knowledge pertaining to standard precautions. Although staff were observed to be complying with the infection control policies and procedures, they are unable to freely access them (refer to 1.2.3.3).</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>Staff education on infection prevention and control has been provided by the IPC nurse (resigned the week prior to the audit). Refer to 3.2.1 All staff have attended infection prevention and control training. Records of attendance are maintained and were sighted. Staff confirmed their understanding of how to implement infection prevention and control activities into their practice. Ministry of Health Covid-19 information is available to all visitors and staff at the facility.</p> <p>Education for residents has occurred as a group activity and informally on a one-to-one basis by HCA's. Topics covered included hand hygiene, Covid-19 information, and the requirement to stay in their</p> |

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| | | rooms if they have an infection. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The Fergusson Home surveillance programme describes the definitions of infections for surveillance the data to be correlated. Infection data is collated monthly. Reports are analysed to identify any trends, possible aetiology and any required actions. Reports are presented at staff meetings, displayed on the staff notice board, and presented to the service owner. The surveillance programme is suitable for the size and complexity of the organisation.</p> <p>There have been no outbreaks of infection since the last audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | PA Low | <p>The nurse manager is designated as the restraint coordinator. The policies on site and the current operator's restraint policies meet the requirements of the restraint minimisation and safe practice standard. Records sampled confirmed that staff actively work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and management team meetings. All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation, and review process. On-going education is provided. There were no restraint interventions in use on the days of audit, but a number of residents had bed levers in place to assist them. Common practice has been that residents sign their consent for use of these and that they are listed in the restraint register. This hasn't been happening.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p> | <p>PA</p> <p>Moderate</p> | <p>Residents and family interviewed were aware of the concept of consent and confirmed that they provided verbal consent prior to the provision of routine care and treatment. They also confirmed that they had given written consent for annual influenza vaccines and Covid vaccines to the service provider who administered the vaccine. Advance care plans were in place in some resident files.</p> <p>Resident files sampled did not evidence written consent for the collection and storage of medical information, routine treatment, information sharing, photographs, or outings. A signed resuscitation status form was not available in all clinical files sampled.</p> | <p>There was no evidence that signed consents had been obtained for all procedures.</p> | <p>Provide evidence of signed consents.</p> <p>90 days</p> |

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| <p>Criterion 1.2.2.1</p> <p>During a temporary absence a suitably qualified and/or experienced person performs the manager's role.</p> | <p>PA Moderate</p> | <p>The interim nurse manager did not demonstrate having the skills and knowledge required for managing the service in a safe and effective manner. This person has no prior experience in managing an aged care facility and is currently holding multiple roles. Responses to auditor enquiries showed a minimal understanding about regulations, contact requirements, and organisational systems including care processes. This has contributed to a number of non-conformances in the quality and risk systems and service delivery. The NM was not informed about staff qualifications including the requirement for a first aid qualified person to be on site twenty four hours a day/seven days a week, the processes for re assessment and transfer of residents requiring a higher level of care, obtaining informed consent, implementation and management of the infection prevention and control programme and the requirements for restraint.. The director stated they would be on site daily for as long as needed henceforth.</p> | <p>The interim nurse manager does not have the skills and experience required to manage an aged care facility.</p> | <p>Increase support for the interim nurse manager and/or implement solutions to ensure day to day services are safe, effective and efficient.</p> <p>30 days</p> |
| <p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management</p> | <p>PA Low</p> | <p>Policies related to the quality and risk management system are documented. The processes as described in policy are not always</p> | <p>The new quality and risk management systems have not been fully implemented. Staff are following previous systems.</p> | <p>Ensure that the company's quality and risk management systems are implemented, fully understood and</p> |

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| <p>system which is understood and implemented by service providers.</p> | | <p>occurring in practice. Staff are following the previous system and the documents in day to day use are not the same as the ones referred to in the system. A system is intact, in so far as new risks are being identified, reported and addressed, monitoring of service delivery is occurring and quality data (incidents, accidents, complaints, outcomes of audits, resident and family feedback) is being collated and analysed for trends. Communication back to staff about the outcomes from quality and risk management did not occur at the most recent staff meeting Minutes recorded there was nil to report under quality, complaints or resident feedback when there had been a survey and internal audit conducted, verbal and formal complaints received, and analysis of incident data. The records show this had been occurring at previous meetings, which is why this nonconformity is reported under this criterion and not 1.2.3.6.</p> <p>The internal audit system in use is wieldy. It is unlikely the current configuration of staff will be able to sustain the same extent and frequency of service monitoring. Furthermore the processes occurring do not match what is described in the current quality and risk policy.</p> | <p>Information and outcomes from quality and risk monitoring was not shared at the last staff meeting. The new quality and risk management systems have not been clearly communicated and shared with staff.</p> | <p>followed by staff.</p> <p>60 days</p> |
| <p>Criterion 1.2.3.3</p> | <p>PA Low</p> | <p>The policies submitted for the stage one document review of this audit</p> | <p>The policy and procedure set is incomplete and does not meet the</p> | <p>Review, update and implement the current</p> |

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| <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p> | | <p>identified eight areas that required addressing. These were not amended prior to the audit. Not all the policies make references to related legislation, regulations, contract requirements or current good practice nor do they cite where the information came from. One reference in the quality/health and safety section, references the superseded Health and Safety in Employment Act 1992. Significant information was missing such as essential notifications under section 31, public health or local government notifications. The accident and incident policy does not guide on notifying family/next of kin or medical officer if required following a resident accident/incident, although there is a separate open disclosure policy. Not all policies required by the aged-related residential care services (ARC) agreement, were submitted specifically pain management, personal grooming and hygiene, falls prevention, and prevention and treatment of pressure injuries. There was no InterRAI policy submitted. However these ARC policies and interRAI policy was not specifically requested for the document review.</p> <p>It was noted during the audit that a number of clinical policies were not specific about the timing of assessments and care plans following entry to the service, and that policies did not always reflect the systems in place. For example, the care planning</p> | <p>requirements of these standards, current legislation and the ARC agreement. Clinical policies and the procedures lack detail and content about timeliness of processes and do not reflect current good practice.</p> <p>Staff have not been educated or informed about the policies or procedures.</p> | <p>policies and procedures to meet the requirements. Ensure all staff are educated about the policies and how to access these.</p> <p>60 days</p> |
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| | | <p>policy refers to entering information in to the Rescall care plan which is not in use, and the team positioned described in human resource policies were not there in practice, such as a wing leader, and clinical leader.</p> <p>The quality system, health and safety, document control, staffing recruitment, training and management and emergency systems are sufficiently described.</p> <p>Evidence was lacking that staff were informed about the new policy set. They did not know where to locate the policies, and there was no evidence that the new policies had been discussed or shared with staff.</p> | | |
| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | PA Low | <p>Processes for developing and implementing corrective actions were not clear in the documents, nor were they able to be verified by staff interview. Staff stated that when an audit identified gaps, for example, missing or overdue information in the residents records, they went ahead and fixed the gap by updating the record. Results of internal audits were documented on the audit records but there was no auditable track about how these were being addressed. The system also lacked evidence that remedial actions taken were being followed up to check that the gap/issue had been satisfactorily addressed. For example, a repeat</p> | <p>There was no documented evidence that actions taken to remedy areas requiring improvement had been implemented to good effect.</p> | <p>Provide evidence that corrective actions are planned and agreed, implemented and then checked to ensure they have fixed the problem.</p> <p>60 days</p> |

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| | | audit, a staff discussion to verify, or seeking management input. | | |
| <p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p> | PA Low | <p>Staff were recording and reporting falls, near misses, skin tears, and bruising and other care related incidents including infection events. An event between residents in January 2022 which was witnessed by visitors was not recorded as an incident nor communicated to the nurse manager. Notes about the event were recorded in a residents file as a behavioural event. The event was later advised to the nurse manager by the local advocacy service representative, after the visitors approached the service about a lack of follow up. This matter has been subsequently addressed and resolved.</p> | <p>An event between residents was not recognised as an incident that required reporting.</p> | <p>Ensure all staff understand the full extent of incident reporting and their responsibility to communicate up all unwanted events.</p> <p>60 days</p> |
| <p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p> | PA Moderate | <p>The formulas used to determining safe staffing levels are based on the 2005 Indicators for Safe Aged-care. This allocates 2.5 hours of RN time per resident each week and 12.6 hours of HCA time. The formula is not taking into account the acuity and needs of residents. At the time of audit three residents were identified as likely hospital level care, two required transfers with a hoist, 11 residents were assessed as high risk falls and there were at least five</p> | <p>Systems for managing planned and/or unplanned staff absences are not established or effective.</p> <p>The formulas used to determining safe staffing levels do not take current residents' acuity and needs into account.</p> <p>Staff who were not trained or assessed as competent have been assisting with resident feeding.</p> <p>There are insufficient numbers of staff maintaining first aid</p> | <p>Implement an effective system for replacing unexpected staff shortages.</p> <p>Review the current number of hours allocated to care staff and housekeeping to ensure these are sufficient to meet current resident's needs.</p> <p>Ensure that only staff who are trained and assessed as competent, carry out</p> |

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| | | <p>residents who required assistance with feeding.</p> <p>Staff shortages are being managed by existing staff doing longer hours and more shifts. The nurse manager stayed on site until after midnight on day one of the audit to cover an unexpected staff absence in the afternoon shift. Staff interviewed described the frequency of requests to do extra shifts/hours and repeated changes to the roster as untenable in the medium to long term.</p> <p>Staff reported that a reduction in the number of care staff allocated for morning shifts had impacted on their workload. This coincided with a change to cleaning staff hours and tasks, which was designed to reduce HCA tasks on the day shift. Refer to further evidence in 1.4.6.</p> <p>The cleaners reported they opted to assist with breakfast service, by clearing trays and feeding residents where required from 8am to 10.30am. Cleaning staff have not been trained or assessed as competent to assist residents with feeding. It was noted that all residents are positioned to be sitting upright before feeding.</p> <p>Staff training records showed that one RN, an EN, two HCAs and the activities coordinator had current first aid certificates. The rosters were not being checked, nor showed evidence that there was at least one staff member on duty with a current first aid</p> | <p>certificates, to cover all duties.</p> | <p>resident cares.</p> <p>Ensure there is at least one staff member with a current first aid certificate on site 24 hours a day seven days a week (24/7)</p> <p>30 days</p> |
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| | | certificate. | | |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA Moderate</p> | <p>Medications were stored securely in a locked room. All medication was labelled with the resident's name and there were no expired medications. Regular recording of room temperature was maintained. Although an air-conditioning unit was installed in the medication room, the unit had not functioned for the past four weeks, and the medication room temperature had consistently reached 25 and 26 degrees Celsius. Controlled medications were stored in a locked metal cabinet within a locked room, and a controlled medication register was maintained. Weekly controlled medication counts had been inconsistently completed; however six-monthly quantity stock takes were not documented</p> | <p>The weekly stocktakes and the six-monthly quantity stock take of controlled medications were not consistently recorded as per legislative requirements.</p> <p>Temperatures in the medication room were higher than desired in storage areas.</p> | <p>Ensure the weekly stocktakes and the six-monthly quantity stock take of controlled medications is consistently recorded as per legislative requirements.</p> <p>Ensure all medications are stored at below 25 degrees Celsius.</p> <p>90 days</p> |
| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | <p>PA Moderate</p> | <p>Although falls assessments were present and regularly reviewed in residents' clinical files, not all files contained all assessments required to meet the resident's needs. Pressure injury assessments were completed upon recognition of pressure injuries in some files sampled. It was stated there were no air pressure mattress' on site. Residents had interRAI assessments completed in required timeframes, and interventions were</p> | <p>Assessments, planning, provision and review of care is not always provided within timeframes to safely meet the needs of the resident.</p> <p>Best known practice for prevention and alleviation of pressure injuries, such as use of an air pressure mattress had not occurred.</p> | <p>Ensure assessments, planning, provision and review of care is provided within timeframes that safely meets the needs of the consumer.</p> <p>Ensure all possible care interventions for prevention and alleviation of pressure injuries are provided.</p> |

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| | | implemented in response to a CAP being raised. In some files sampled the resident's needs had increased significantly with the resident requiring extensive staff input, however referral to NASC to reassess for hospital level care had not occurred. | | 90 days |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Low | <p>Inspection of the ORA apartment confirmed the space was suitable for delivery of rest home level care. The layout and fixtures inside the dwelling are safe and promote safe mobility. All furniture was removed and electrical supply shut off, so not all systems could be tested. There was a full sized oven and washing machine in place. Call bells need to be installed (refer criterion 1.4.7.5) and cooking equipment removed or disconnected. Residents need to be advised about the system for repairs and maintenance, if these are different to what was in place under the ORA.</p> | <p>Not all systems could be tested as the electrical supply was shut off and there was no furniture. There are cooking appliances in place. Electrical systems, internal and external access and the apartment will need to be inspected when furniture is in place to confirm a safe environment. The existing systems for repairs and maintenance need to be explained to residents.</p> | <p>Disconnect the oven. Ensure the electrical systems and all areas in the apartment (including layout of furniture) are safe for people requiring rest home level care. Ensure the intending residents understand the system for requesting repairs and maintenance.</p> <p>Prior to occupancy days</p> |
| <p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p> | PA Low | <p>Two cleaners are on site Monday to Friday from 8am to 1.30pm and 8am to 2.30 pm. The cleaner who does the longer shift is responsible for laundry on those days. A dedicated laundry person is rostered each weekend from 8.30 to 1.30pm. Afternoon HCAs and night-time staff carry out specified laundry (folding and ironing) and cleaning tasks. There are no cleaners</p> | <p>The hours currently allocated for cleaning may not be able to meet the additional demand for cleaning in the previous ORA apartment</p> | <p>Review the impact of additional cleaning areas with staff and ensure there are adequate hours for cleaning allocated before the two residents return to the apartment.</p> <p>Prior to occupancy days</p> |

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| | | <p>on the weekend. Staff said this allows enough cleaning hours for residents rooms/ensuites and common areas (hallways) to be fully cleaned and sanitised once a week, spot cleaning of bathrooms and all areas is occurring on an as needed basis. Care staff state that due to the current acuity of residents, they only have enough time to carrying out essential cleaning on the weekend, such as emptying rubbish from resident's rooms. This increases the workload for cleaners on a Monday.</p> | | |
| <p>Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.</p> | <p>PA Moderate</p> | <p>Staff understand the current emergency systems and attend regular evacuation practices. Future trial fire evacuations will need to include whoever is living in the apartment. Systems for alerting these residents to fire or the need for an emergency evacuation need to be tested.</p> | <p>It is not known if the approved evacuation scheme includes the ORA apartment located at the end of A wing.</p> <p>Trial fire evacuations that include the ORA apartment and its occupants have not yet occurred.</p> | <p>Review the current evacuation scheme with Fire and Emergency Services New Zealand.</p> <p>Test the effectiveness of the emergency alert system in the apartment before residents move in.</p> <p>Ensure the residents have been part of a trial emergency evacuation.</p> <p>Prior to occupancy days</p> |
| <p>Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.</p> | <p>PA Low</p> | <p>A feasibility inspection for installing three call bell points in the apartment has occurred. The owner/operators are advised and expect to undertake the cost for this.</p> | <p>There is currently no call bell system in the ORA apartment.</p> | <p>Install a call system into the apartment. Ensure this is functional and integrated with the current rest home call system.</p> |

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| <p>Criterion 1.4.7.6</p> <p>The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.</p> | PA Low | <p>The apartment is easily accessed from the rest home and there is an outside entrance via a small flight of stairs. This has always been open and accessible to other residents however. There is a television monitoring system in place which covers the corridors and wing where the apartment is located. Wandering is not identified as a concern for either resident.</p> | <p>The location and ease of access to the apartment has potential security threats for rest home residents.</p> | <p>Review the current security arrangements for A wing and ensure that rest home residents living in the apartment are kept safe.</p> <p>Prior to occupancy days</p> |
| <p>Criterion 3.2.1</p> <p>The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.</p> | PA Moderate | <p>At the time of the audit there was no one on staff who had the expertise to implement the infection control programme. The IPC nurse is responsible for implementing the infection control programme, however the IPC nurse position had become vacant the week prior to the audit, and the role had not been allocated to another member of staff. During the audit there was no staff member able to discuss the implementation of the programme in 2022. The GP was identified as being a resource should further expertise be required.</p> | <p>There is not a person on staff with the expertise or range of skills required to implement the infection control programme.</p> | <p>Ensure there is a person on staff with the expertise or range of skills required to implement the infection control programme.</p> <p>30 days</p> |
| <p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least</p> | PA Low | <p>There were a number of bed levers in place that assist residents with getting up and repositioning themselves in bed. These do not limit or restrict</p> | <p>There are no consent for use of bed levers signed by residents.</p> | <p>Ensure that residents who use bed levers have been assessed as competent and that placement of these is</p> |

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| <p>restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p> | | <p>freedom of movement and are solely intended to promote resident independence and safety. Common practice is that these type of devices are recorded as enablers that competent residents sign consent for. There was no documentation related to this. Bed levers could pose a risk to confused people, so all residents who use them need to be assessed as competent and sign their own consent. If these are not voluntary or signed by a third party, they could be considered restraint.</p> | | <p>safe. Obtain the residents signed consent for their use.</p> <p>90 days</p> |
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there 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.