Roseanne Retirement Limited

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:	Roseanne Retirement Limited
Premises audited:	Roseanne Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 May 2017 End date: 31 May 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	16

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Roseanne House provides rest home level care for up to 16 residents. Occupancy during the audit was 16 residents.

The audit was conducted against the relevant Health and Disability standards. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

The service is owned and managed by a registered nurse and supported by a stable staff. All family and residents interviewed spoke positively about the care and support provided by staff and management.

This audit has identified improvements required in relation to: internal audits, two yearly mandatory training, interventions, medication management and review of the infection control programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Residents and staff report full information is provided at entry to residents and family/representatives. Regular contact is maintained with family. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

Roseanne has a documented quality and risk management system. Key components of the quality management system link to relevant facility meetings. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. All staff have an orientation on employment and there is an annual training plan in place for staff. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

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

There is an admission package. The registered nurse is responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting support, needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and were reviewed at least six monthly. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. All staff that are responsible for administration of medicines complete annual education and medication competencies.

One activities coordinator oversees the activity programme for the residents. The programme runs during week days and the activities coordinator organises and covers some activities offered in evenings and weekends.

There is a well-equipped kitchen with all meals and baking cooked on site. Resident food preferences, dietary and cultural requirements are identified at admission, in an ongoing manner and are accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

The building holds a current warrant of fitness.

Restraint minimisation and safe practice

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

There are policies around restraint, enablers and the management of challenging behaviours. The service currently has no residents requiring the use of restraint or enablers.

Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	4	1	0	0
Criteria	0	39	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. There are complaint forms available at the entrance to the building. A complaints procedure is provided to residents and their family within the information pack at entry. Interview with three residents and two relatives confirms an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints. One complaint was received in 2016 and no complaints have been made in 2017 year to date. The one complaint reviewed evidenced follow-up and that it had been resolved. The complainant signed a formal acknowledgement letter confirming satisfaction with how the complaint was managed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is an open disclosure policy, a complaints policy and an incident and accident policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed identify that family were notified following a resident incident. Two family members interviewed stated they were well informed and involved when needed in residents' care. Resident/relative meetings occur three monthly. The resident survey (February 2017) is documented as presented to and discussed with family and residents.

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Roseanne rest home provides care for up to 16 rest home residents. At the time of the audit there were 16 residents (including one resident on respite). The quality plan has nursing objectives related to a resident focus. The owner/manager is a registered nurse who owns and manages the facility. She has extensive experience in rest home care and has owned the service since 2010. She has worked at the facility since 2004. The owner/manager is supported by a part-time administrator (32 hours). All staff interviewed state that they receive good support from the owner/manager who can provide advice at any time. There was a business plan for 2016. Communication and reports against day-to-day information and quality outcomes is achieved through three monthly staff/quality meetings and bi-monthly health and safety meetings. The owner/manager attends at least eight hours a year training relevant to requirements.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has in place a range of policies and procedures to support service delivery. There is a documented audit schedule in place, however not all audits are completed according to the schedule. Audits are reported to the three-monthly staff meetings and six-weekly health and safety meetings. Staff interviewed were all able to explain the staff and health & safety meeting and how they are used to discuss problems and improve services. Quality data is collected and evaluated and used for quality improvement. Key components of the quality system link to service delivery. Health and safety meetings document reporting of incidents and accidents, infection control, restraint, health & safety, audits, training complaints and other matters. The minutes reviewed were well documented. Staff meetings (three monthly) document discussion of falls data and care of residents including strategies to improve care. Resident/family meetings occur regularly and are documented. The resident survey completed in February 2017 has been collated and presented to residents and family. There is a health & safety and risk management programme in place. The hazard register is up-to-date and has been reviewed.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or	FA	Incident and accident data has been collected and analysed. Incidents and accidents are documented as reported to the health and safety meeting and individual incidents discussed with staff. A sample of twelve resident related incident reports were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. Three caregivers interviewed could explain the importance of neurological observations. Monthly collation of incident forms highlights residents with more than one incident (i.e.,

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.		falls). These residents are documented as followed up.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Roseanne retirement home employs 14 staff. Five staff files (three caregivers, one diversional therapist and one cook) reviewed all included (but not limited to) a signed job description, employment contract and appraisals and training records. Annual practicing certificates are on file for all registered staff including the owner/manager, GP and pharmacist. An annual in-service education programme is in place. The annual training plan covers a range of subjects and attendance is recorded on staff records. Not all two yearly compulsory mandatory training has been completed as required. First aid training has been provided and there is a first aider on each shift. There are implemented competencies for staff related to medication with all relevant caregivers.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service continues to have a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/manager is on site at least 50 hours per week. She has been filling a caregiver night shift role (three days a week) for the past two months. A new caregiver is set to start in the vacant night shift role from early June 2017. The owner/manager is on-call at all times. A RN from a neighbouring rest home also assists with on-call and support as needed. Three caregivers interviewed stated that there is adequate staffing to manage their workload on any shift and that the owner/manager is always available if needed. The owner/manager is supported by two caregivers on duty in the AM shift, two caregivers in the PM shift and one caregiver at night. All care staff are trained in first aid. All residents and family members interviewed confirm that there are sufficient staff on site at all times and staff are always approachable and in their opinion, competent and friendly. A senior caregiver is the manager/owners 2IC and is in charge when the manager/owner is not there.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Monthly medications received (robotic rolls) are checked on delivery by the manager (RN) and senior medication competent caregiver. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored weekly. Nine of ten medication charts (one respite resident) reviewed, met legislative prescribing requirements. The GP has reviewed the medication charts three-monthly. Administration records demonstrated that not all medications are signed as administered and one respite resident did not have a current medication chart and medication was being administered. Medication errors were documented on incident forms and investigated with competencies of staff being reviewed where appropriate. The internal auditing programme includes medication audits completed by the manager. There was no documented evidence of six monthly pharmacy checks.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Roseanne are prepared and cooked on site in a fully equipped commercial kitchen. There is a four-weekly seasonal menu which had been reviewed and approved by a dietitian November 2016. Meals are delivered to the dining area immediately upon serving. A tray service is available upon request. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. Supplements and high protein snacks and drinks are provided to residents with identified weight loss. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge and freezer temperatures are taken and recorded and meet requirements. End cooked food temperatures are recorded daily. Food was stored correctly. All staff working in the kitchen have completed training in food safety and hygiene and chemical safety. There is a maintained cleaning schedule. Kitchen waste is managed appropriately.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and	PA Low	When a residents' condition alters, the registered nurse initiates a review and if required a GP consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families were documented in the resident's progress notes. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Initial wound

appropriate services in order to meet their assessed needs and desired outcomes.		assessments and ongoing evaluations were in place for two residents with minor wounds. There is access to a wound nurse specialist at the DHB as required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Short-term care plans document appropriate interventions to manage short-term changes in health such as infections. Care plans reviewed did not include interventions to support all assessed needs. Monitoring forms are used (e.g., observations, weight, behaviour, blood sugar levels and neurological signs).
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	An activities coordinator (AC) typically works a minimum of 12 hours per week Monday to Friday. The activity hours are flexible and allows for attendance and organisation of special events at weekends and evenings according to resident wishes. Caregivers assist with individual and group activities during the week and on weekends. Residents are involved with organising and managing certain activities. One resident organises band music, another oversees the gardening and maintains a raised vegetable garden. The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes van outings, church services, games, gardening and exercise. Local kindergarten and school groups visit often. Recently seven residents went out to see a film. A local retirement home visits and vice versa where they run bowling competitions and include trophies. Van outings take residents to local sites of interest and included recent visits to the chocolate factory, central Hawkes Bay Settler's Museum, Mitre 10 for the men and clothing shopping trips for the women. Canine friends visit with animals. On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities. The activities coordinator is responsible for the resident's individual activity care plans which are developed within the first three weeks of admission. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Resident files reviewed identified that the individual activity plan is reviewed six-monthly and evidence outcomes achieved against goals set. Activities are planned that are appropriate to the functional capabilities of residents and are mostly driven by resident requests. Residents provide feedback individually and via an annual resident satisfaction survey and they make suggestions for activities at the resident meetings. Residents and families interviewed report satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are	FA	All initial care plans reviewed were evaluated by an RN within three weeks of admission. In all files sampled the long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur and are documented within the progress notes. Files reviewed demonstrated that short-term needs were documented on short-term care

evaluated in a comprehensive and timely manner.		plans which were regularly evaluated.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires 16 November 2017.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low	The infection control nurse is the manager (RN). She can access external specialist advice from GPs and the DHB when required. The IC programme is appropriate for the size and complexity of the service. Infection control is a standing agenda item at the health and safety meetings. Staff are informed about IC practises and reporting. Suspected infections are confirmed by laboratory tests and results are collated monthly by a registered nurse and entered into the infection register. There are policies and an infection control manual to guide staff to prevent the spread of infection. The infection control programme has not been reviewed annually.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified	FA	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place that are appropriate to the complexity of service provided. There have been no outbreaks since the previous audit.

in the infection control programme.		
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraint, enablers and the management of challenging behaviours. The service currently has no residents requiring the use of restraint or enablers. Staff received training around restraint minimisation as part of the annual training plan.

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is a quality and risk plan that includes an audit calendar schedule. Not all audits have been completed as per the calendar schedule.	A review of the audit calendar schedule and audits evidences that audits are not always undertaken. Ten audits scheduled for April and May 2017 have not been completed as per the calendar.	Ensure that all audits are completed as per the calendar schedule. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide	PA Low	Abuse and neglect, sexuality/intimacy, and care planning mandatory training identified by the service has not been provided in the last two years.	Abuse and neglect, sexuality/intimacy, and care planning mandatory training identified by the service has not been provided in the last two years.	Ensure all staff attend compulsory mandatory training requirements at least every two years.

safe and effective services to consumers.				90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Nine of ten (one respite resident) medication records reviewed, demonstrated that GPs prescribe and review medications regularly. Indications for use for 'as required' medications were documented. The medication round observed (by one caregiver) demonstrated appropriate practice. However, review of documentation demonstrated that medications prescribed were not always signed as administered and one respite resident had no medication chart documented and medication for that resident was being administered. There was no documented evidence of pharmacy checks completed for Roseanne Retirement Home.	(i) Three of ten medication administration records sampled did not have all prescribed medications signed as administered. (ii) One respite resident did not have a prescribed medication chart in place at time of audit. (iii) There were no documented six-monthly pharmacy checks completed.	(i) Ensure that for all prescribed medications administered are signed for once administered. (ii) Ensure that all residents have a prescribed medication chart for all medications. (iii) Ensure pharmacy checks are completed six monthly as required. 30 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	(i) One resident on respite had no documented interventions to guide care. iii) One resident with diabetes had no documented interventions to manage hypo/hyperglycaemia; however the caregivers interviewed could describe appropriate actions. iv) One resident with pain identified as a problem had no documented interventions to manage pain and there was no documentation to identify pain was being managed.	Four of five files sampled did not document interventions in address all assessed needs. (i) One resident on respite had no documented interventions to guide care. iii) One resident with diabetes had no documented interventions to manage hypo/hyperglycaemia; however the caregivers interviewed could describe appropriate actions. iv) One resident with pain identified as a problem had no documented interventions to	(i) Ensure respite resident file has documented interventions to guide care (iii) Ensure resident with diabetes has documented interventions to manage hypo/hyperglycaemia (iv) Ensure sufficient interventions are documented to manage residents'

			manage pain and there was no documentation to identify pain was being managed.	pain 90 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The infection control programme has not been reviewed annually.	There has been no review of the infection control programme	Ensure the infection control programme has been reviewed 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.