Patrick Ferry House Limited - Patrick Ferry House

Introduction

This report records the results of a Certification 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:	Patrick Ferry House Limited
Premises audited:	Patrick Ferry House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 June 2017 End date: 22 June 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 62

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

Patrick Ferry House provides rest home and hospital (geriatric and medical) level care for up to 74 residents and on the day of the audit there were 62 residents. The service is managed by an experienced manager. The residents and relatives interviewed all spoke positively about the care and support provided.

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

This audit has identified the following areas requiring improvement around completing corrective actions and interRAI training to meet timeframes.

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.

Staff at Patrick Ferry House strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. 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.

The quality and risk management programme includes: the service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.		Standards applicable to this service fully attained.

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and were reviewed at least six-monthly. Resident files included medical notes by the contracted GP, and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three-monthly by the general practitioner

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families report satisfaction with the activities programme.

Kitchen staff have completed food handling certificates. Residents with special dietary needs have their needs reviewed six-monthly as part of the care planning process and these needs are identified in their care plans. Special equipment is available. Residents and family interviewed were complimentary about the food service. All meals are prepared on site. Individual and special dietary needs are catered for and alternative options are available for residents with dislikes. The menu has been reviewed by a dietitian.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Rooms are individualised. There are large spacious lounges and dining areas. There are adequate toilets and showers. The internal areas can be ventilated and heated. There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are safe and easily accessible. Cleaning services are well monitored through the internal auditing system. Laundry is completed on site by dedicated laundry staff.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

Restraint minimisation and safe practice

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently nine residents require restraint for their safety. There are three enablers currently in use. Staff are trained in restraint minimisation.

Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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	48	1	1	0	0	0
Criteria	0	99	1	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (sixteen healthcare assistants, three registered nurses (RN), two clinical coordinators, one diversional therapist, one clinical manager, one hospital manager and one general manager) confirm their familiarity with the Code. Interviews with eight residents (three rest home and five hospital) and six families (two rest home and four hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. Code of rights training including: advocacy, informed consent, privacy and elderly abuse are part of the mandatory training days that staff undertake which are facilitated twice a year to ensure all staff attend. This was held in March 2017.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are	FA	Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs written consents. Eight resident files were reviewed (six hospital - including one interim care, one ACC, and two rest home), demonstrated that consent forms are discussed and completed on admission. Residents and staff confirm that they are aware that consent can be withdrawn at any stage. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed

provided with the information they need to make informed choices and give informed consent.		confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and included consents.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.
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. There are complaint forms available. Information about complaints is provided on admission. Interview with residents and families demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints. There is a complaint register. Verbal and written complaints are documented. There have been 14 complaints in 2017 year to date. The complaint documentation was reviewed. All complaints had noted investigation, timeframes, corrective actions when required, and resolutions were in place if required. One complaint was referred to a Health and Disability Advocate and since the draft report has been closed out with resolution. Results of investigations into any complaints raised are fed back to complainants. Discussions with residents and families confirmed that their issues are addressed and they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested.

Rights During Service Delivery Consumers are informed of their rights.		Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the hospital manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met. There is a policy that describes spiritual care. A pastor and a representative from the Catholic Church visit regularly. All residents interviewed indicated that residents' spiritual needs are being met when required.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. The service has links with Awataha Marae. There is a Māori health plan. There were no residents who identified as Māori on the day of the audit. Discussions with staff confirm that they are aware of the need to respond to cultural differences and described how they would document the care plans for the specific cultural requirements of Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. The service has recently introduced a new initiative called "Food for the Soul", which is incorporated into the activity programme. This initiative aims to meet the spiritual needs of the wide range of multicultural residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness (mandatory training day in May 2017).
Standard 1.1.7: Discrimination	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The registered nurses supervise staff to ensure professional practice is maintained in the

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey was sent out in January 2017 and the 12 completed survey forms returned (sighted) demonstrated high levels of satisfaction with the services provided. The resident meeting has a standard agenda that asks the residents for ideas each month about how to improve the service. There was evidence that the residents' feedback (as appropriate) is acted upon. Residents interviewed spoke very positively about the care and support provided and stated the management team are very approachable. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms indicated whether the family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Patrick Ferry House is an aged care facility located on the North Shore. There are 74 dual-purpose rest home and hospital(geriatric and medical) level beds. On the day of the audit there were 62 residents. The service is provided over two levels. On the day of audit, there were 31 residents across the 39 rooms on the ground floor – 25 hospital and 6 rest home. On level one, there were 31 residents across the 35 beds - 22 hospital - including two residents admitted under an interim care contract and one ACC funded resident, and nine rest home residents. A business plan is in place for 2017. A mission, philosophy and objectives are documented for the service. The manager completes a weekly report for the general manager and then meets at least fortnightly to

		review the day-to-day operations and to review progress towards meeting the business objectives. The hospital manager has previous health management experience and has been in her role at this facility since January 2016. The hospital manager is supported by a clinical manager. The clinical manager has worked at Patrick Ferry House as a registered nurse for five years and has been in the clinical manager role for seven months. The hospital and clinical managers have maintained a minimum of eight hours of professional development relating to managing an aged care service.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the hospital manager, the clinical manager is in charge with support from the two clinical coordinators, the general manager and the other care staff.
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	A quality and risk management programme is in place. Interviews with the general manager, hospital manager, clinical manager, clinical coordinators, care staff and cook, reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data and complaints management. Data is being collected monthly, and analysed or trended and the results are communicated to staff. Corrective actions are documented and communicated to staff but not consistently reviewed and signed out. Falls prevention strategies are implemented for individual residents. A number of quality improvements have been made since the last audit, including implementing a new registered nurse handover process at the bedside of each resident, the implementation of an acuity tool to

		assist with resident allocation, an updated care pathway for the prevention of pressure injuries, and the introduction of moving and handling preceptors. Although the quality data being captured does not yet show a consistent trend in improved resident outcomes, improvements have been noted. A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (a registered nurse) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review May 2017).
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an accidents and incidents reporting policy. The hospital manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings. A registered nurse conducts clinical follow-up of residents. Ten incident forms sampled from June 2017 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the hospital manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.
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 Negligible	There are human resource management policies in place. This requires that relevant checks are completed to validate the individual's qualifications, experience and veracity for new staff. A copy of practising certificates is kept. Eight staff files were reviewed (one clinical manager, one registered nurse, two healthcare assistants, one diversional therapist, one cook, one laundry person, and one cleaner) and evidence that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2016 has been reviewed and a plan for 2017 is being implemented. The registered nurses have completed competencies relevant to the care of hospital - medical clients, (e.g., fundamentals of palliative care, syringe driver training). The hospital manager and registered nurses can attend external training, including sessions provided by the local DHB. Three of eight registered nurses have completed interRAI training, and four registered nurses are currently completing their training. Annual staff appraisals were evident in all staff files reviewed.
Standard 1.2.8: Service Provider Availability	FA	Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The hospital manager is onsite Monday to Friday and is on call after hours.

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		The hospital manager and the clinical manager work Monday to Friday and share the afterhours on call. On a morning shift on each floor there is a clinical coordinator (registered nurse) rostered on Monday to Friday. On the ground floor on a morning shift there is a registered nurse and five healthcare assistants, and on an afternoon shift there is a registered nurse and four healthcare assistants - three long and one short shift. On level one on a morning shift there is a registered nurse and five healthcare assistants - three long and one short shift and on an afternoon, there are thee healthcare assistants on a full shift. On nights, there are two healthcare assistants on each floor and a registered nurse who works across both floors. The registered nurse on nights does not attend to residents in the attached village. The healthcare assistants respond to the village call bells at night and if required, the RN will arrange for the village resident to be transferred to Patrick Ferry for closer monitoring or if required arrange for a transfer to the DHB. The care staff interviewed advised that additional staff are provided when there is an increase in resident care needs. Activities staff are rostered on five days per week. There are separate domestic staff who are responsible for cleaning and laundry services. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Seven of eight admission agreements viewed were signed and dated. One hospital resident had not signed the ARRC agreement as they were admitted under an interim care scheme.

been identified.		
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Policies and procedures clearly document the service provider's responsibility in relation to each stage of medication management; and medicine management information is recorded to a level of detail and communicated as needed to consumers. There are currently two residents self-medicating. These residents have the required self-medicating assessments in place and their medications are kept securely in a locked drawer in their rooms. The facility uses a robotics system for regular medication and a medico pack system for PRN medications and controlled drugs. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses who have passed their medication competency administer medications. Medication competencies are updated annually and staff attend annual education. There are standing orders and these meet legal requirements. The medication fridge temperatures are checked daily. Eye drops are dated once opened. Staff sign for the administration of medications on medication administration sheets. Controlled drugs are checked out by two people. The controlled drugs register is checked twice weekly. Sixteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications have indications for use charted.
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 Patrick Ferry House are prepared and cooked on-site. There is a qualified chef and a cook that covers the seven-day week. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Meals are plated in the kitchen and then served in the ground floor dining room. Food is delivered in a bain marie to the upstairs kitchenette. Both dining rooms have a first and second meal service ensuring those requiring additional assistance have their dignity maintained and meals served at an acceptable temperature. End cooked meal, and fridge and freezer temperatures are recorded. Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food

		preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at mealtimes. Residents were observed enjoying their lunch in one dining room and a healthcare assistant was observed assisting a resident to eat in their room. Residents' meetings allow for the opportunity for resident feedback on the meals and food services. Residents interviewed were complimentary of the food and confirmed alternative food choices were offered for dislikes. All staff who work in the kitchen have completed food safety and hygiene, and chemical safety training. All foods were date labelled and stored correctly.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Not all files sampled contained an up to date interRAI assessment (link 1.2.7.5), however other nursing assessment tools (e.g., pain, pressure injury risk, falls risk, behaviour monitoring) were evidenced and used when there was a change in health condition.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	All care plans were resident centred. Interventions documented; support needs, were detailed and provided sufficient information. Residents and family members interviewed stated they were involved in the care planning process. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There was evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist, physiotherapist, wound care nurse, dietitian and mental health care team for older people. The

		care staff interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the RN will initiate a GP consultation. Staff state that they notify family members about any changes in their relative's health status. Eight out of eight care plans sampled had interventions documented and these had sufficient detail to guide care. Care plans had been updated as residents' needs changed. Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted. Wound assessment, wound management and evaluation forms are available for all wounds. The service is proactive in ensuring all skin issues are reported. There are currently 34 wounds being monitored and treated. Wound monitoring occurred as planned. The facility has access to wound care specialist advice if required. There are currently five pressure injuries, which are all documented on wound care forms and have corresponding incident forms as part of the reporting requirements. Four of these pressure injuries were non-facility acquired and only one was facility acquired. Advised that the facility acquired pressure injury was due to the resident's refusal to be turned. Appropriate links are developed and maintained with other services (interim care) and organisations (DHB) that are working with consumers and their families. Monitoring forms are in use as applicable such as weight, bowel charts, two hourly pressure relief, restraint monitoring, vital signs and wounds.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs an activity team of two staff (one diversional therapist (DT) and one activity coordinator who is in her first week of orientation) to coordinate and implement the integrated rest home/hospital activities programme. The programme is delivered Monday to Friday and includes a wide variety of activities that both hospital and rest home level residents report as interesting and meaningful to them. These include but are not limited to; exercises, games, crafts, painting, pet therapy and quizzes. The diversional therapist holds a current first aid certificate. There is a monthly large print programme on the noticeboard. "Food for the soul" is a fortnightly activity and time of sharing and reflection that focuses on the resident's spirituality where residents can sing hymns and read poetry if they desire. Catholic Church volunteers come in as needed to give communion to those who request it. Pastoral care for other denominations can be organised as requested according to residents' individual needs. Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they

		need and to have a chat. The diversional therapist has introduced individual activity boxes for those residents that prefer not to participate in activities, these boxes are individualised to the residents' activity preferences e.g., crosswords, model building and puzzles. Residents and families have the opportunity at meetings and during discussion to provide suggestions for activities, entertainment and outings. Residents are encouraged to maintain links with community groups such as local primary school visits and fellowship groups. Monthly visits from a local primary school are enjoyed and residents are able to interact by singing and reading with the young children. Fortnightly pet therapy visits are a firm favourite with all residents. There are also regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. Regular happy hour is enjoyed every Friday. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly. Activities progress notes are completed monthly for all residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Seven of seven long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. The resident admitted on an interim care contract also evidenced regular review of their care plan. Short-term care plans were evaluated and signed off as resolved or added to the long-term care plan if the condition became chronic. Activities plans are in place for each resident and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home residents and one-monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.

consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Aged residential care is provided on two levels (the ground floor and level one) on one side of the building, with services and parking for all areas located in the basement level. The other side of the building has 50 private apartments and is operated as a retirement village. All care rooms are dual-purpose with disability friendly ensuites. Some rooms have ranch sliders to the exterior and others have access to a deck area. Each room has an electric hospital bed except for one room where the rest home resident has chosen to use their own bed. The building has a current building warrant of fitness (8 January 2018). The person responsible for the village maintenance also oversees the reactive and planned maintenance programme for the care facility. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored, and maintained in resident areas between 42 and 45 degrees Celsius. Action is taken if the temperatures are outside of the accepted range. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene	FA	The service has sufficient toilet and showering facilities to meet the need of the residents. Every room has an ensuite and all rooms have a hand basin. The service has adequate hand washing facilities in common areas and there are a number of alcohol hand gel dispensers throughout the premises. Toilet and showers are identifiable and have appropriate signage when in use. There are separate toilets for staff and visitor use.

requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. All resident rooms are large enough to allow for the use of hospital level equipment. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	On the ground floor, there is a lounge and a dining area. On level one there is a large lounge, where the group activities for both levels of care are held, and one large dining area. All lounge and dining areas have sufficient space to accommodate the equipment used by residents admitted under the hospital medical component of care. There is sufficient space to allow for group and individual activities to occur in both lounges. Residents can move freely and furniture is well arranged to facilitate this. Residents were observed to be moving freely both with and without assistance throughout the audit.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are dedicated cleaning staff at the service. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and families interviewed were satisfied with the standard of cleanliness in the facility. There are dedicated laundry staff who complete all laundry onsite in an appropriately appointed laundry. On the day of audit one commercial washing machine was out of use and the service was waiting on a machine part to be replaced. The service was currently outsourcing the laundering of the sheets and towels. Residents interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas

and security situations.		cooking. Short-term back-up power for emergency lighting is in place. All staff are trained in first aid and cardiopulmonary resuscitation (CPR) and are available at all times. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The building is well designed with lots of natural light and internal atriums. All bedrooms and lounges have windows of a large size that open to the outside of the building and include security stays for safety. Many of the bedrooms have sliding doors, which open out onto either an internal courtyard or a protected balcony for each room. Heating is a mix of underfloor gas and electricity. There are temperature gauges located throughout the facility to guide staff on the internal temperatures. Smoking is only permitted in one designated area by residents and staff, which is on the ground floor. The building is smoke free.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Patrick Ferry House has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the clinical manager, the infection control committee and all other staff. Infection control is an agenda item at the monthly staff meetings. Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse at Patrick Ferry House is the designated infection control (IC) coordinator and is supported by the clinical manager. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC committee (comprising the hospital manager, clinical manager, clinical coordinators, domestic staff, laundry staff and healthcare assistants) have good external support from the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are Patrick Ferry House infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed training in infection control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Patrick Ferry House's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the hospital manager. There have been two outbreaks since the previous audit, one in August 2016 and one in May 2017, and both were well managed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively	FA	There are policies and procedures around restraints and enablers. Nine hospital residents were using restraint (8 bedrails and one lap belt), and three hospital residents were using enablers (bedrails) on the day of audit. Assessments were completed and written consent was provided by the resident or families for the

minimised.		restraints and by the three residents using enablers. Staff interviews confirmed their understanding of the differences between a restraint and an enabler. Staff receive regular training around restraint minimisation and the management of challenging behaviour that begins during their induction to the service.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	A registered nurse and the clinical manager are the restraint coordinators. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the nine restraint and three enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed, appropriate interventions were in place to ensure resident safety and care needs are met. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enabler register, which is up updated each month.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly staff meetings.

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed	PA Low	Where the quality data identified improvements were required, corrective action plans were documented and implemented. There was evidence in the staff meeting minutes the corrective actions required were discussed at staff meetings. Not all corrective actions that were implemented were reviewed and signed out once completed, including but not limited to, safe handling, restraint, accident and incidents, medication documentation and complaints management.	Corrective action plans are not consistently reviewed and signed out once completed.	Ensure that corrective action plans are consistently reviewed, and signed out once completed. 90 days

and implemented.				
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Negligible	The registered nurses complete relevant clinical assessments and use this information to develop the care plan. Six of six care plans reviewed, where an interRAI assessment was required, had not had an interRAI assessment documented or completed within the required timeframes. One of six files sampled (hospital) had an interRAI assessment last documented eight months prior to audit, and five of six files (two rest home and three hospital) did not have any interRAI assessment documented. The service has implemented a corrective plan in consultation with the DHB to support the service to meet the contractual requirements regarding the use of interRAI which includes: attempting to recruit consulting interRAI trained nurses, scheduling of two staff members to be interRAI trained per month, contact with Technical Advisory Services (TAS) regarding their delay in marking registered nurses interRAI assessments, and monthly review of interRAI assessment backlog and time-tabling of these with trained nurses to ensure completion. The service had three of their interRAI trained RNs resign and therefore were left with only their Clinical Manager (1 RN) who was interRAI trained. They endeavoured to secure places on the interRAI training for their newly employed RNs, however, there were no places available for a few months. Advised, they recruited a consultant who would complete their interRAI assessments and an interRAI trained RN from the bureau but both were not able to go ahead for various reasons	Some residents have not had interRAI assessments completed. This is due to the resignation of a trained interRAI assessors which the provider has taken steps to replace, however the scheduling of training for the new staff, which is beyond the control of the provider, has led to a delay in the carrying out of interRAI assessments	Continue to ensure RNs access training to meet contractual timeframes around assessments 180 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.