

Sunflower Field Trading NZ Limited - Summerville Rest Home

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:	Sunflower Field Trading NZ Limited
Premises audited:	Summerville Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 September 2018 End date: 21 September 2018
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:	12

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
Yellow	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
Red	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

Summerville Rest Home provides rest home level care for up to 15 residents. On the day of the audit there were 12 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The managing director manages the business remotely and is supported by the manager. The service is overseen by the manager who has been in the role for 28 years. She is supported by a part-time RN who has been in the role for three months. Residents and family members interviewed spoke positively of the services provided at Summerville Rest Home.

This certification audit identified areas for improvement relating to notification of incidents and documented interventions.

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.		Some standards applicable to this service partially attained and of low risk.
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The staff at Summerville Rest Home 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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

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.		Standards applicable to this service fully attained.
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Summerville Rest Home has a documented quality and risk management programme. Progress with the quality and risk management programme has been monitored through the monthly quality/staff meetings. Data is collected on complaints, accident/incidents, infection control and restraint use. There is a current business plan in place. Resident/relative meetings are held six monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The internal audit schedule for 2018 is in place. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Residents are assessed on entry to the service. There are entry and admission procedures in place which include interRAI assessments. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whānau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. There is a medication management system in place and each resident is reviewed at least three monthly by their general practitioner. A range of individual and group activities are available and coordinated by the activities officer. All meals are prepared onsite and the kitchen is the hub of the rest home. There is a menu in place which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents report satisfaction with the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are lounges and a dining area, and small seating areas throughout the facility. Furniture is appropriate to the setting and arranged to allow

residents to mobilise. There is a designated laundry, which includes storage of cleaning and laundry chemicals. Chemicals are stored in a locked storage cupboard. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

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.
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Summerville Rest Home has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training in restraint minimisation and challenging behaviour management.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. There is a suite of infection control policies and

guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

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	43	0	2	0	0	0
Criteria	0	91	0	2	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	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with four care staff, including one registered nurse (RN), two caregivers and one activities coordinator confirmed their familiarity with the Code. Five residents and two-family members interviewed confirmed the services being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has policies and procedures relating to informed consent and advanced directives. All five files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.
Standard 1.1.11: Advocacy And	FA	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information pack provided to residents prior to entry

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available in the service entrance. Information about complaints is provided on admission. Interviews with five residents and two relatives confirmed an understanding of the complaints process. There have been no complaints made since the last audit. The manager stated that any complaints received would be managed appropriately with acknowledgement, investigations and responses recorded.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the manager or RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are informed about the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity,</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Staff receive training on abuse and neglect, which was last completed in September 2018.</p>

privacy, and independence.		
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	The service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were no residents that identified as Māori. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training on cultural safety and Treaty of Waitangi, which was last completed in 2017.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and that family involvement is encouraged.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The quality and risk management programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The manager is responsible for coordinating the internal audit programme. Monthly quality/staff meetings and six-monthly resident meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by management.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	PA Low	The manager promotes an open-door policy. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. However, there was no documented notification to the next of kin for 12 of 14 accident/incident forms reviewed. Five residents interviewed confirmed that the staff and management are approachable and available. The information pack is available in large print and advised that this can be read to residents.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Summerville Rest Home provides rest home level care for up to 15 residents. On the day of the audit there were 12 residents, including one resident on a mental health contract. All other residents were on the age related residential care (ARRC) agreement.</p> <p>Summerville Rest Home is owned by a non-New Zealand registered medical practitioner. He assumes the role of managing director only. The managing director manages the business remotely and is supported by the manager. The service is overseen by the manager who has been at Summerville Rest Home for 28 years and in the manager role for 18 years. She has a certificate in management. The manager has worked in the health care and aged care sectors for a vast number of years. She is supported by a part time RN who has been in the role for three months and she works 12 hours a week. The service has an annual business plan for 2018 in place, including annual goals, action plans, responsibilities and date/timeframes.</p> <p>The manager has maintained eight hours of professional development in the past 12 months.</p>
<p>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.</p>	<p>FA</p>	<p>The manager reported that in the event of her temporary absence, the RN fills the role with support from care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>Summerville Rest Home has a documented quality and risk management system. Progress with the quality and risk management programme has been monitored through the monthly quality/staff meetings. The monthly quality/staff meeting includes discussion around internal audits, health and safety, infection control, accident/incident data, complaints, food service and restraint as needed. The minutes of these meetings are documented. The service has resident meetings every six months with the activities coordinator. The activities coordinator also meets with every resident individually on a</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>weekly basis (not documented). There are a range of policies, associated procedures and forms in place. Policies are reviewed two yearly (last reviewed in February 2017) to meet the requirements of the relevant Health and Disability Services Standards 2008 (policies were sighted). The service has a 2018 business plan in place. Progress toward previous 2017 goals has been monitored regularly.</p> <p>The 2018 annual resident and relative satisfaction survey has been conducted with respondents advising that they are overall very satisfied with the care and service they receive. The satisfaction survey results have been discussed at the quality/staff and resident meetings. There is a wall planner with a schedule of internal audits. The service reviews all internal audits six-monthly and action plans are followed up through quality/staff meetings. Corrective actions are completed for any internal audits that are not fully compliant. There is a Health and Safety and risk management system in place including policies to guide practice. There is a current hazard register, which was last reviewed in August 2018. Hazards are documented on the register and have interventions documented to manage the risk. Falls prevention strategies are in place, which include the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Fourteen accident/incident forms for the month of June, July and August 2018 were reviewed. All document timely review and follow-up. Neurological observations (Glasgow coma scale report) were documented and completed for two unwitnessed falls with potential head injury. However, there was no documented evidence that family had been notified for 12 of 14 incidents reviewed (link 1.1.9.1). Discussions with the manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Five staff files (one manager, one RN, two caregivers and one activities coordinator) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. A current practising certificate was sighted for the RN. The service has an orientation programme in place to provide new staff with relevant information for safe work practice.</p> <p>Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The RN and caregivers' complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. The RN has completed interRAI training and has also</p>

		attended education sessions at the district health board (DHB).
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a policy on staff numbers and skills required. Skill mix is reviewed on a regular basis and reviewed in-line with resident numbers. The manager is onsite from 8.00 am until 4.00 pm Monday to Friday and is on-call 24/7. There is a part-time RN onsite for 12 hours per week or more if required and is also available on-call 24/7 for any clinical issues. The local general practitioner (GP) also provides after hours care if required and caregivers have access to the local ambulance service. The caregivers, residents and family members interviewed reported that there is sufficient staff on duty.</p> <p>There are two caregivers on duty on the morning shift, one caregiver on duty on the afternoon shift and one caregiver on the night shift. There is an additional caregiver who covers the 'tea' shift from 5.00 pm to 8.00 pm. Roster shortages or sickness are covered by casual or off duty staff. There is also a senior caregiver who lives onsite and is available for any assistance if required. There is a cleaner seven days a week from 8.30 am to 11.30 pm and an activities coordinator who works Monday to Friday from 10.30 am to 12.00 pm.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is a policy in place that includes resident admissions. Needs assessments are required prior to entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on services available. Residents and or family/whānau are provided with associated information (eg, information on their rights, the Code, complaints management, advocacy, and the admission agreement). The family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. The current version of the admission agreement aligns with the expectations in the aged residential care agreement and includes exclusions from the service.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are guidelines for death, discharge, transfer and follow-up. When transferring, all relevant information is documented and transferred with the resident. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification for resident transfers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (i.e., eye drops and ointments) are dated once opened.</p> <p>Education on medication management has occurred with competencies conducted for the RN and caregivers with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three monthly. The medicines administration round at lunchtime was witnessed and conducted correctly. No residents self-administer medicines and there were no controlled medications onsite. Residents/relatives interviewed stated they are kept well informed of any changes to their/relatives' medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food is prepared and cooked onsite by the caregivers who are assigned to cooking duties on the roster. Baking and some food preparation is done by the night staff. There is a four weekly, summer/winter menu in use that had been reviewed by a dietitian December 2017. The main meal is at midday. The resident likes, and dislikes are noted on admission and known to the caregivers. Alternatives are offered. Special diets are accommodated. Care staff have completed safe food handling training. High calorie diets and supplements are offered for residents with weight loss, if needed. Lip plates and smaller serving plates are available to promote independence at meal times.</p> <p>The kitchen is well equipped with gas hobs, electric oven, freezers, one fridge/freezer and dishwasher. All perishable goods are date labelled. Fridge/freezer temperature monitoring and hot food temperature monitoring is occurring. Chemicals are stored in a lockable cupboard. Food is procured from local commercial suppliers and the supermarket. Residents and relatives spoke positively about the meals and home baking. Resident meetings provide an opportunity for resident feedback on the meals. A food control plan with an expiry date of February 2019 is in place.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service would record the reason (no bed availability or unable to meet the assessed level of care) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The facility has embedded the interRAI assessment protocols within its current documentation. InterRAI assessments were evident in printed format in all files. All resident files included an up-to-date interRAI assessment. InterRAI assessments were reflected into care plans, with the exception of risks associated with medical condition (link 1.3.5.2).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The resident files reviewed were integrated and promoted continuity of service delivery. The GP, allied services, the RN, activity staff, physiotherapist and other visiting health providers write their care notes in the resident file. The service uses a care plan template that was individualised, however interventions for one resident's health risk were not documented. The care plans reviewed described the resident needs and care interventions required to support the resident's independence and wellbeing. Care plans are available to guide caregivers. Caregivers interviewed were knowledgeable regarding individual resident cares. There were short-term care plans in use for short-term needs (wounds sighted). There is documented evidence of resident/family input into care planning and six-monthly reviews.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>All resident files reviewed had care plans in place. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RN interviewed.</p> <p>Caregivers and the RN interviewed, stated there is adequate continence and wound care supplies. Documentation was reviewed for the one wound – a surgical wound following removal of a carcinoma. Instructions given following surgery and from the district nurse were being followed. Evaluation of the wound (including photographs) were evident. There were no pressure injuries. Monitoring charts</p>

		were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one activities officer employed, a non-practicing RN, who is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. The activities officer is employed for 10 hours per week over four days. Caregivers assist with individual and group activities programmes at other times during the week and at weekends, along with a volunteer one day a week. Each newly admitted resident has an individual activities assessment and a social assessment completed and an individual activities plan is developed, however the individual activities plans do not always align to the activities assessment and the interRAI assessment. The individual activities plan is reviewed six monthly when the resident's care is reviewed. A weekly plan is developed and is displayed in the passageway, which may change as necessary.</p> <p>Residents have the opportunity to provide feedback and suggestions for future activities, outings and entertainment (at the start of each day the activities officer is on, an informal meeting is held with residents over a cup of tea where residents are encouraged to offer their views/ideas). The programme is flexible and accommodates community visitors and groups. Entertainers come three times a month and a disability taxi is hired for outings for larger groups. Residents are supported to attend their own church and are transported by families. Special events and festive occasions are celebrated. On the day of the audit, residents were observed being actively involved with a variety of activities including external entertainers. The group programme includes residents being involved within the community with social clubs, churches and schools. A record is kept of individual resident's activities and monthly progress notes completed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents and their care plans are evaluated using the interRAI process at least six monthly or if there has been a significant change in their health status. The RN also documents a weekly review of the resident's care provided and outcomes. The GP reviews residents three monthly or when requested if issues arise or their health status changes. The GP was interviewed and stated that the staff communicate appropriately. Short-term care plans were evident for the care and treatment of residents. Short-term care plans are typically used for residents with infections and those who have wounds.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	FA	<p>The service facilitates access to medical and non-medical services. The RN interviewed confirmed that residents and family are informed of any referrals made directly to other nursing services or the</p>

<p>(Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>needs assessment team. Referrals to DHB staff and medical specialists are made by the GP in consultation with the RN. Relatives and residents interviewed, stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There is a waste and hazardous substance safety policy. Management of waste and hazardous substances are covered during orientation of new staff and as scheduled on the education planner. All chemicals sighted were labelled correctly and were stored in locked areas. Safety datasheets are available. Gloves, aprons, and goggles are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires 11 January 2019. Two of the double bedrooms are currently occupied by one resident only. The building has internal and external ramps on the ground floor. There is a planned and a reactive maintenance programme in place. There is a communication book used for the daily maintenance requests. The manager coordinates and authorises the contractors to carryout maintenance requests. Corrective actions are documented in the communication book. The manager is available on call for urgent matters. Electrical equipment not hard wired has been tested and tagged annually.</p> <p>Hot water temperature monitoring is completed monthly with readings within acceptable ranges. There is storage for equipment and supplies, although space is limited. The interior of the home is well maintained and homely. There is an open plan combined dining area/lounge area and a second lounge area available. Residents were observed to be moving freely around the facility with the use of mobility aids. There is outdoor seating and shading in place. The grounds are well maintained. There is a safety gate across the driveway with plenty of street parking.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured</p>	<p>FA</p>	<p>No resident bedrooms have hand basins or ensuite bathrooms. There are four resident communal toilets and a separate toilet for staff and visitors. There are three showers for residents. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. There are privacy locks on the doors on the showers and toilets. Residents interviewed confirmed staff provide the resident with privacy when attending to personal hygiene cares.</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. Bedrooms are personalised.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There is easy access to the communal areas. The dining area and main lounge area is open plan where activities take place. There is a second large lounge at the front of the building where residents can have visitors or spend time with quiet activities. Communal areas are accessible. There is adequate space to allow for individual and group activities to occur within the lounge.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There is a cleaner employed for three hours daily (seven days a week). The cleaner is also responsible for processing laundry. Caregivers also undertake the cleaning and laundry. Laundry procedures and cleaning duties are documented. There is a commercial washer and a commercial drier and sink in the laundry. Linen is dried outside on the clothesline where possible. The laundry door is latched to prevent resident entry when staff are not in attendance.</p> <p>Chemicals are stored safely in the manufacturer's containers in the laundry and in other locked areas. Safety datasheets are readily accessible. Protective clothing is available for staff and chemical training occurs. The effectiveness of the cleaning and laundry service is monitored by the manager through resident and relative feedback, the internal audit programme and resident meetings. Residents interviewed were satisfied with the cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate</p>	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There is an emergency and business continuity plan in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the

<p>and timely response during emergency and security situations.</p>		<p>last fire evacuation drill occurring on 18 July 2018. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (bottled water supply), blankets and alternate gas cooking (BBQ and gas hobs in the kitchen).</p> <p>There are civil defence and pandemic outbreak supplies available. There is a first aid kit kept in the kitchen and nurses station. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The RN holds a current first aid certificate. There is a call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas are well ventilated. Bedrooms have an external window to allow natural lighting and ventilation. Fans and external doors are used in summer to remove heat from the building. There are oil-filled heaters in the bedrooms and panel heaters in the corridors and communal areas, which are used continually during the winter months. The residents confirmed the temperature of the facility is comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control (IPC) programme is appropriate for the size and complexity of the service. The RN is the infection prevention and control officer. The facility has a suite of infection prevention and control policies. The infection prevention and control practices are authorised and reviewed annually by the RN. The infection prevention and control programme results are discussed at the general staff meetings. Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents and staff. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of</p>	<p>FA</p>	<p>Infection control is managed by the infection control coordinator (RN) who has been in the role for three months. She has a job description for the role included in her contract. The infection control coordinator has undertaken IC training (June 2016) and is currently registered to undertake online training for the role. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP.</p>

the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The infection control manual outlines a range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed (February 2017).
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing, and standard precautions and training was provided both at orientation and as part of the annual training schedule. A record has been kept of staff attendance.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place and are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	Summerville Rest Home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint-free environment. Staff receive training in restraint minimisation and challenging behaviour management.

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. However, there was no documented notification to the next of kin for 12 of 14 accident/incident forms reviewed. Family are asked on admission if they wish to be notified of any accident /incident relating to their family member. This is recorded on the resident register, advised that most only want to be notified if major or causes change to cares.	Fourteen accident/incident forms were reviewed for June, July and August 2018. There was no documented notification to the next of kin for 12 of 14 accident/incident forms reviewed.	Ensure that documentation reflects that next of kin are notified of any resident incidents/accidents or if not notified, the reason why should be documented. 90 days
Criterion 1.3.5.2 Service delivery plans describe	PA Low	The service uses a care plan template that is individualised to resident need, and interRAI assessments, and risk assessments form the basis	One resident who is insulin dependent has no guidance/interventions for staff relating to (hypo or hyperglycaemia - including the BSL level at which the GP	Ensure that care plans document all resident needs and required

<p>the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>of the long-term care plan.</p>	<p>wished to be informed) and actions to be taken. Noting they do have general guidance information re: guidance/intervention for staff relating to hypo or hyperglycaemia on a chart on the wall in the nurses station.</p>	<p>management interventions. 90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.