

Fergusson House Restcare Limited - Fergusson House

Introduction

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

The audit has been conducted by HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Fergusson House Restcare Limited

Premises audited: Fergusson House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 10 March 2021 End date: 11 March 2021

Proposed changes to current services (if any): The rest home is being sold. The prospective provider does not intend to change the current services provided.

Total beds occupied across all premises included in the audit on the first day of the audit: 36

Executive summary of the audit

Introduction

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

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

General overview of the audit

Fergusson Home and Retirement Village is undergoing a prospective change of ownership. The rest home currently provides rest home level care for up to 44 residents. The service is privately owned and operated and is one of two facilities owned by the same provider. The rest home is managed by a nurse manager. The nurse manager is supported by registered nurses and the management team based at the current organisation's head office. Residents and families spoke positively about the care provided.

This provisional audit was conducted to assess how well prepared the prospective owners are to own/manage the rest home, and the extent to which the existing provider is conforming to the requirements against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner.

There were no areas identified as needing an improvement during the audit. One area of continuous improvement was identified.

Consumer rights

Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code), and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner. The prospective owner has a good understanding of consumer rights legislation.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers in the community.

The complaints process meets consumer rights legislation. A complaints and concerns register is maintained.

Organisational management

Fergusson Home is currently owned and governed by the directors. The purpose, values, scope, direction and goals of the organisation will remain the same following the proposed purchase. Day to day operations are currently the responsibility of the nurse manager and the management team. The prospective provider has a defined governance structure with three directors who are suitably qualified. Organisational performance is monitored through monthly management reports.

The quality and risk management system will remain the same and includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. The prospective provider is aware of legislative and compliance requirements, Policies and procedures support service delivery, best practice and were current and reviewed regularly.

Human resource policies and procedures are in place and are implemented. The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is securely maintained, integrated, current and up to date.

Continuum of service delivery

The entry to service pathway is clearly outlined in the policies and procedures sighted. Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurses (RNs) at the service.

Activities plans are completed by the diversional therapist (DT) and activities coordinator (AC) respectively. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place. Day-care services are provided for residents from the facility village and the community three times a week.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration, RNs, and healthcare assistants (HCAs) are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

Safe and appropriate environment

The building is appropriate to the needs of the residents and was purpose built. All equipment was observed to be in good working order. Well-furnished communal areas, dining and external areas are accessible to all residents. The facility has plenty of natural light and is maintained at a comfortable temperature. Bedroom areas are sufficient in size to allow for personal possessions and

accommodate mobility aids, equipment and staff caring for the resident. Toilet and bathroom facilities are sufficiently equipped and well maintained. Maintenance is maintained in an ongoing manner. Applicable building and fire regulations are met.

Cleaning and laundry service meet infection control requirements and are of a good standard. Collection, storage and disposal of waste is in accord with council and infection control principles. Staff comply with safe waste and hazardous substances procedures.

Appropriate processes are in place to maintain the safety and security of residents at all times. The organisation has sufficient supplies in the event of an emergency or pandemic.

The prospective provider has no intention to make changes to the building.

Restraint minimisation and safe practice

The organisation has documented policies and procedures that support the minimisation of restraint. There were no residents using restraints or enablers on the day of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff education on restraints, enablers and the management of challenging behaviour is provided.

Infection prevention and control

The infection control management systems are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed, and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

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	45	0	0	0	0	0
Criteria	1	92	0	0	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	<p>The organisation has documented policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The Code is displayed around the facility and provided to residents and family/whanau as part of the admission process.</p> <p>The prospective/owner demonstrated a good understanding of the consumers rights legislation. The prospective owners have previously owned and managed rest home facilities in Auckland, New Zealand and are familiar with how the Code is implemented in everyday practice.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The consent policy and procedure references consumer right legislation, including competency/mental capacity. There is also a policy on advanced directives. Staff interviewed understood the principles and practice of informed consent. The service was able to demonstrate that written consent is obtained where required. Clinical files sampled confirmed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA), or residents, and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for daily cares. Interviews with residents and relatives confirmed the service actively involves them in decision making.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>As part of the admission process residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this and their right to have support persons. The NM and staff provided examples of the involvement of advocacy services in relation to residents' care.</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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending to a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours (unless restrictions required due to the current COVID-19 pandemic national alert levels) and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</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>	<p>FA</p>	<p>The complaints policy and procedure meets consumer rights legislation. Information on the complaint process is provided to residents and families on admission. Residents and family members confirmed their understanding of the complaints process. Complaint forms are easily accessible. The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>Verbal concerns and written complaints are required to be entered onto the complaints register. There have been no formal written complaints since the last audit. Verbal concerns were documented and included the actions taken. Action plans sighted confirmed improvements had been made where required. The management of concerns and complaints is included in the internal audit schedule. The most recent audit confirmed full compliance to the complaints process. It was reported that there have been no complaints to, or from, external agencies.</p> <p>Resident meetings are also an avenue for residents to voice any concerns. Records of resident meetings confirmed that concerns were taken into consideration by the management team, with follow up where required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents are informed of their rights during entry to service and through the service delivery process. Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. All residents will receive a copy of the code, this will be provided in English and Maori; and other languages as appropriate and interpreters will be used as required. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process.</p> <p>The admission pack outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district</p>

		<p>health board requirements.</p> <p>The Code is always on the agenda at each resident meeting every month. Documented evidence of this was sighted in the minutes reviewed. This has resulted in a continuous improvement rating.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home level of care. Residents were able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p>
<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	<p>Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training and there are five staff members who identify as Maori. There is an assessment for Māori residents. Cultural needs are included in the care plans, if identified. There is access to cultural advice, resources, and documented procedures. There were residents who identified as Maori and cultural needs were included in the care plans sampled. There were also staff members of Maori descent. Policies and procedures regarding the recognition of</p>

		Maori values and beliefs are documented. The Maori Health Plan was currently being reviewed to ensure it meets the requirements of the agreement with the district health board (DHB).
<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	<p>Cultural needs are identified on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident and family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed. There is cultural diversity amongst staff including Maori, South African, Indian, Pilipino and Pasifika.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are documented policies and procedures in place to prevent and minimise incidents of discrimination, coercion, and harassment, sexual, financial, or other exploitation at the service. Family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The nurse manager (NM) stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff and education for residents. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness</p>

		<p>of medical interventions when medical requests are sought.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The organisation supports and maintains competencies for staff in manual handling, hand washing, medication administration and interRAI assessments. Most staff have level three and level four industry approved qualification.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Communication continued to be maintained even during COVID-19 pandemic lockdown throughout all national alert levels announced by the Ministry of Health (MOH). This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal health and medical information is collected to facilitate the effective care of residents.</p> <p>There were no residents who required the services of an interpreter however staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The organisation is owned and directed by the chief executive officer (CEO) of The Main Group. The Main Group own several businesses, including aged care facilities and retirement villages. There is a senior management group which consists of the CEO, business manager, operations and human resources manager, administration manager, purchasing and maintenance manager, management support person (who oversees the quality system) and the nurse managers from the aged care facilities. The senior management group meets quarterly which this forum used to discuss any issues/risks and review the progress of any quality actions and improvements.</p>

		<p>The CEO and business manager monitor organisational performance through monthly management reports. Reports sighted include information on input, outputs and outcomes such as financial management, occupancy, complaints, health and safety, adverse events, audits and quality improvements. The business plan is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans.</p> <p>The rest home is certified for up to 44 beds. The service holds contracts with Lakes DHB for respite care and rest home level care. At the time of audit one resident receiving services under the Short-Term Residential Care Respite contract (discharging on the day of the audit) and 38 residents receiving services under the Age-Related Residential Care Contract.</p> <p>One of the prospective owners was interviewed. It is proposed that future ownership and governance will be the responsibility of three new directors. One of whom has a background in nursing and has previously owned/managed three aged care facilities, one of whom is an accountant and one of whom works as a registered valuer of aged care facilities and villages. Two of the new directors have had previous experience as board members in the aged care sector. The new directors will adopt the current vision, mission and values of the organisation.</p> <p>The prospective owners have a defined organisational structure. This includes three directors/owners. All three of the prospective owners have previous experience with the aged care sector and retirement villages. One of whom has previously managed/owned aged care facilities, two of whom have been on the board of an aged care provider, and one of whom is a chartered accountant.</p> <p>There is a documented transition plan. Proposed ownership takes effect on the 31st March 2021. It was reported that the current management structure will remain in place during the transition period. One of the new owners was a registered nurse and will be responsible for the day to day management of the rest home during the transition period. Following the transition period, the current management team will be contracted to provide continued support for as long as it is considered needed. This was confirmed by the</p>
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		prospective owners and the current management team.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Day to day management of services is the responsibility of the nurse manager. The nurse manager has been employed by the organisation as a registered nurse for four years, and recently moved into the management role. The nurse manager worked as second in charge to the previous nurse manager. The nurse manager has no previous experience in management, however, is supported by four other member of the management team who are on site weekly and available as required. It was reported that this support will continue following the change it ownership. The nurse manager has full support of staff and the management team and is scheduled to attend leadership training. The nurse manager's curriculum vitae confirmed the required clinical skills for the role. The Ministry of Health has been notified regarding the appointment of the new nurse manager.</p> <p>Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at in-service training and education, at quarterly Lakes District Health Board (LDHB) age care meetings, and age-related conferences.</p> <p>The prospective owners confirmed there will be no immediate changes to the management team.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Policies and procedures include all necessary aspects of the service and contractual requirements. Policies are based on best practice and are constantly monitored by the senior management group to maintain currency. All policies and procedures are personalised for Fergusson Home. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Policies are accessible in SharePoint and provided in a 'read only' version.</p> <p>The organisation has a planned quality and risk system that reflects</p>

		<p>the principles of continuous quality improvement. This includes management of adverse events and complaints, internal audits, resident and family satisfaction surveys, monitoring of outcomes and health and safety. There is an internal audit schedule and evidence of implementation. Audits are delegated to staff. A register of corrective actions is maintained.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the weekly clinical management team meeting, the monthly staff meeting and quarterly senior management meeting. All quality data outcomes are posted on the staff notice board (sighted).</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (July 2020) confirmed that all issues raised were fully addressed and the outcomes were discussed at the residents' meetings and at staff meetings.</p> <p>Risk management processes are in place. Insurances are current and accounts are independently audited annually. The health and safety representative and management support person described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There is a comprehensive risk management plan which covers the scope of the organisation. The health and safety representative is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There is an up to date hazard register in place which clearly describes the hazard, the risk level, mitigating actions and who is responsible for the control of the hazard.</p> <p>The prospective provider intends to maintain the same quality and risk management system and adopt the current quality plan. The schedule of internal audits will continue, as will other quality related activities. The prospective provider was aware of legislation requirements and had considered risks associated with the transition and the aged care sector.</p>
Standard 1.2.4: Adverse Event Reporting	FA	There is a formal process for the reporting and management of adverse events. This process is overseen by the health and safety

<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>representative and the nurse manager. Staff document adverse and near miss events on an accident/incident form. Incident forms sampled confirmed appropriate immediate actions, investigation, the development of action plans and closure. Adverse event data is collated, analysed and reported to the senior management group and at staff meetings.</p> <p>The most common event is falls, which is monitored through the falls prevention programme. Staff and residents are constantly reminded of strategies to aid in the reduction of falls. There was evidence resident records that neurological observations were implemented in the event of an unwitnessed fall, and that family were notified as required/consented.</p> <p>The management team described essential notification reporting requirements, including situations that required reporting to the Ministry of Health. The prospective provider was also aware of reporting/legislative requirements including health and safety, employment legislation, MOH and DHB requirements.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes the essential components of service delivery and tasks relevant to the role. Staff reported that the orientation process prepared them well for their role. Completed orientation and a performance review after a six-week period and then annually were sighted in staff records sampled.</p> <p>Continuing education is planned annually. Education includes mandatory training requirements. Education for 2020 was provided from the current owners other aged care facility. This includes an eight hour session for the health care assistant and another session for the registered/enrolled nurses. All staff are required to attend the annual education days and records of attendance are maintained.</p>

		<p>The 2021 training plan is currently under review, with education commencing in March and April 2021.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. At the time of the audit there were 11 care staff with a level four certificate, one with level three, one with level two and the remaining staff on level one. There are sufficiently trained and competent registered nurses, two of whom are maintaining their annual competency requirements to undertake interRAI assessment, with the new registered nurse scheduled to commence the training.</p> <p>The health and safety representative ensures that the required ongoing competencies are maintained. This includes manual handling, restraint, hand washing and medication competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting good access to advice is available when needed. Care staff reported there are enough staff available to complete the work allocated to them, with staffing 10% above recommended staff staffing levels at the time of the audit. Residents and family interviewed supported this. Observations and review of rosters confirmed more than adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>The nurse manager works 40 hours per week. There are two nurses on the morning shift, seven days per week. There are six care staff on the morning shift, three on the afternoon shift and two overnight. There are dedicated cleaning and kitchen staff seven days a week. Laundry is undertaken as part of the care staff duties. There are two activities staff and a designated maintenance person. On call duties are shared between the nurses. Members of the senior management team are also available should they be required. An audit of staff</p>

		<p>numbers and skill mix was conducted in February 2021 with no corrective actions identified. The prospective provider intends to maintain the current staffing levels during the transition period and will review this in an ongoing manner dependent on occupancy and acuity.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Residents' records are held both electronically and paper based. Staff have individual passwords to the residents' records data base, such as the medication management system and on the interRAI assessment tool. The visiting GP and allied health providers also have access to the system which supports integration of residents' records.</p> <p>Some residents' records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely. Hard copy archived records are stored safely and securely on site. There is an effective system for retrieving both hard copy and electronically stored residents' records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.</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>The entry to service policy includes all the required aspects on the management of enquiries and entry. Fergusson Home and Retirement Village admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</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>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</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>	FA	<p>The medication management system is implemented to ensure that residents receive medicines as prescribed and in a timely manner. The medication entries sampled on the electronic system complied with legislation, protocols, and guidelines. Medications are stored in a safe and secure way in the treatment rooms and locked cupboards. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in. Medication reconciliation is conducted by the RNs when the resident is returned back from hospital or any external appointments. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated, and photos uploaded for easy identification.</p> <p>Visual inspection revealed no expired or unwanted medicines, staff said these were returned to the pharmacy as soon as possible. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Monitoring of medication room temperature was maintained. An annual medication competency is completed for all staff administering medications and medication training records were sighted. A care staff member was observed administering medication correctly. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted, and all medications were stored appropriately. Outcomes of pro re nata (PRN) were documented in the progress notes. Evidence of medication audits and corrective actions completed were sighted.</p> <p>There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of</p>

		medication if required.
<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>	FA	<p>There is an approved food plan for the service which expires 18 June 2021. Meal services are prepared on site and served in the respective dining areas. The menu was reviewed by a dietitian within the past two years. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. The residents' weight was monitored regularly, and supplements provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Thermometer calibrations were completed every three months. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</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 nurse manager reported that all consumers who were declined entry are recorded and when a potential resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</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>Residents have their level of care identified through the needs assessment by the needs assessment agency (NASC). The initial assessments were completed within the required time frame on admission while care plans and interRAI were completed within three weeks according to policy. Assessments and care plans are detailed</p>

		and include input from the residents, family/whanau, and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans were resident focussed, integrated, and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals were specific and measurable, and interventions were detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives confirmed care delivery and support is consistent with their expectations and plan of care. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, district nurses, physiotherapist, NASC team, dietitian, and GP.</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>Interventions in the residents' service delivery plans were relevant to address the assessed needs and desired goals/outcomes. All significant changes were reported in a timely manner and prescribed orders carried out. The GP reported that communication was conducted in a transparent manner, medical input was sought in a timely manner that medical orders were followed, and care is person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs,</p>	FA	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' files sampled</p>

age, culture, and the setting of the service.		<p>reflect their preferred activities and were evaluated regularly or as when necessary. The diversional therapist and the activities coordinator develop a monthly activity planner which covers activities for the rest home and day-care residents. These were posted on the notice boards in residents' native language to remind them of upcoming activities. Residents' activities information was completed in consultation with the family during the admission process. Activities included celebration of residents' birthdays, van outings, board games, regular walks, music, pet therapy, newspaper reading, national and events of the world. Participation record is completed which details level of engagement rated on a scale of either active, passive or declined. The service also provides day care services for residents from the facility's retirement village and people from the community. These are conducted three times a week and only a maximum of six residents per session is allowed. Residents' meetings are conducted monthly where various issues are discussed.</p> <p>The residents were observed participating in a variety of activities on the day of the audit. There are planned activities and community connections that are suitable for the residents. Regular outings were completed for all residents except under COVID-19 alert level one and two. Residents and family/whanau interviewed reported overall satisfaction with the level and variety of activities provided.</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' long term care plans, interRAI assessments and activity plans were evaluated at least six monthly and updated when there were any changes. Six week following entry, and annual meetings with family were conducted evaluating residents' care and evidence of this was sighted. Relatives, residents, and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans were developed when needed and signed and closed out when the short-term problem has resolved.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family were kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The health and safety manual, housekeeping manual and infection control manual all include information on the management of waste and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff know what to do should any chemical spill occur. Trade Waste consents were sighted in the laundry and the kitchen. Domestic rubbish is removed from the facility as per council requirements. There is provision and availability of protective clothing and equipment (PPE) and staff were observed using this during the audit. Additional supplies of PPE are available in the event of an outbreak. Sharps containers are available and oxygen cylinders/equipment is safely stored. There have been no adverse events regarding waste and hazardous substances.</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>	FA	<p>The rest home facility was purpose built and is on the grounds of the retirement village. The rest home is divided into three main wings, with the communal area and administration at the centre of the facility. The rest home is surrounded by well-maintained grounds. There is a current building warrant of fitness. Furnishings and furniture are fit for purpose and consider the needs of the residents.</p> <p>There is a designated maintenance person on site three days a week, and as required. Preventative and reactive maintenance activities are maintained. Additional maintenance activities include a wide range of regular checks and monitoring of the building. For example, alarms, call bells, hot water temperatures, mobility</p>

		<p>equipment maintenance, routine cleaning of gutters, windows and heat pumps. The facility has residual current device (RCD) protection which ensures electrical safety is maintained. Medical equipment is calibrated.</p> <p>Residents confirmed they knew the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they were happy with the environment. The hazard management system ensure any hazards are identified and managed accordingly. A hazard register is maintained.</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 privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of toilets and bathing facilities. Of the 39 rooms, 37 rooms have ensembles plus two rooms with a shared bathroom. These rooms were occupied by residents of the same gender. There are designated toilets for staff and visitors, and a toilet close to the communal area. Toilets had raised seats as required. Hand sanitiser is placed throughout the facility. Hot water temperatures are routinely monitored, with corrective actions as required. Residents and family/whanau interviewed expressed no concerns regarding toilet and bathing facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 39 bedrooms across the three wings, five of these rooms can accommodate couples which takes the total number of beds available up to 44. There were no residents sharing rooms at the time of the audit. All private bedrooms were well furnished, including personal belongings. Rooms are of differing sizes, with all able to accommodate equipment and personal items.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	FA	<p>There is a large communal area/lounge in the centre of the building. This area is used for recreation and activities. The lounge is large enough to accommodate a quiet area for those who do not wish to participate in the daily activities. The communal area/lounge is adjacent to the dining room and is well furnished, with adequate and</p>

needs.		suitable seating. There is a small library in one of the wings, which can be used by all the residents.
<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>The House Keeping manual includes cleaning and laundry processes. All laundry is undertaken on site by the care assistants. The laundry is well equipped with identified clean and dirty areas. There is a large drying room. Residents reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training. Chemicals are provided by an external provider using a closed chemical system. All chemicals were stored securely and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme, resident meetings and satisfaction surveys.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning directs the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 1 April 2002. Smoke alarms are installed and fire extinguishers located throughout the building. A trial evacuation takes place every six months with a copy sent to the New Zealand Fire Service. The orientation programme includes fire, emergency and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, mobile phones, gas BBQ's and a civil defence kit. An emergency water storage tank is located in the complex, and there is a generator on site. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks</p>

		the premises at night.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by a combination of gas boiler and panel heaters. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There is a designate area for smoking well away from the building in the event that a resident who smokes is admitted.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The rest home provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The clinical support person who is a qualified registered nurse is the infection control coordinator (ICC) who oversees three other sister facilities and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. Regular updates and information on COVID-19 is provided to staff, families, and residents. Restricted visiting times are put in place in response to national COVID-19 pandemic alert levels.</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 the organisation.</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The organisation has documented policies and procedures in place that reflect current best practice. Policies and procedures are accessible and available for staff. These were last reviewed in February 2020 and have been updated to include COVID-19 requirements. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and have access to policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. An infection prevention and control orientation guide for new staff and outbreak information folder was sighted. All staff attend an annual infection prevention and control training at their head offices with 33 staff attending a donning and doffing training in April 2020. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines, including COVID-19 requirements. External contact resources include GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The ICC reported that an infection control record is completed when a resident has an infection, documents are sent to the ICC and entered in the infection prevention control register, which is reported to management monthly. Benchmarking is completed against another sister facility. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Records sampled confirmed that staff actively work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and management team meetings. All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation, and review process. On-going education is provided. There were no residents using enablers or restraint at time of the audit. The nurse manager is the restraint coordinator</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.	CI	Each resident meeting begins with a discussion on one of the Rights of the Code and how it is implemented in everyday practice. A recent meeting also included a discussion on the history of the Code, including why and when it was developed. Residents interviewed confirmed an increased understanding regarding their individual rights, consumer rights legislation and how a better understanding of their rights has improved their understanding and confidence in voicing their needs and concerns. Satisfaction surveys over a period of time included comments regarding improved understanding.	Ongoing education for residents on consumer rights legislation has improved their understanding.

End of the report.