

# Care Alliance 2016 Limited - Waimarie Private Hospital

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## 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 The DAA Group 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:

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| <b>Legal entity:</b>  | Care Alliance 2016 Limited   |
| <b>Premises audited:</b>  | Waimarie Private Hospital  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| <b>Dates of audit:</b>  | Start date: 8 January 2018 End date: 9 January 2018  |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 36   |

# Executive summary of the audit

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

## General overview of the audit

Waimarie Private Hospital provides rest home and hospital level care for up to 52 residents. The service is privately owned and operated by two owner/directors who purchased the facility in March 2017. One owner/director manages non-clinical aspects of care (business manager) and one is a registered nurse who oversees clinical aspects of care. There is a newly appointed experienced registered nurse facility manager (December 2017) who manages the day to day services. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, the clinical charge nurse from Auckland City Hospital who oversees interim care residents at the facility, and a general practitioner.

This audit has identified four areas requiring improvement relating to timeframes for service provision, assessment, food services, and building maintenance.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There were no residents who identified as Maori at the time of audit. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively. There was one open complaint at the time of audit.

## Organisational management

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| 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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. A suitably qualified person manages the facility.

The quality and risk management system 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. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Staff training records are kept up to date. 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 accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for.

## Safe and appropriate environment


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| 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. |  | Some standards applicable to this service partially attained and of low risk. |
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The facility meets the needs of residents. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

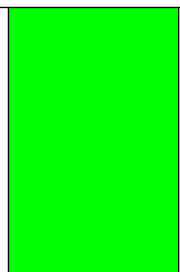
Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

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| 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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The organisation has policies and procedures that support the minimisation of restraint. Three enablers were in use at the time of audit. No restraints were in use. Policy contains a comprehensive assessment, approval and monitoring process should restraint be required. Use of enablers is voluntary for the safety of residents to enable them to remain as independent as possible. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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| 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 prevention and control programme, led by an infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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                           | 41                  | 0  | 3                                    | 1  | 0                                      | 0  |
| Criteria          | 0                           | 89                  | 0  | 3                                    | 1  | 0                                      | 0  |

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome   | Attainment Rating | Audit Evidence   |
|---|-------------------|--|
| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>  | FA                | <p>The facility has developed policies, procedures and processes to meet its obligations 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 employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and include advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent being defined and documented. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Where a resident is deemed incompetent to make an informed choice, the enduring power of attorney (EPOA) is enacted and consent on behalf of</p> |

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|  |    | the resident. Staff were observed to gain consent for day to day care.   |
| <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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The facility acknowledges an advocate/spokesperson who is a resident at the facility. Residents interviewed stated that staff and management listen to any concerns/suggestions made, discussions are had, and resolutions occur in a timely manner.</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 young and older are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips and entertainment. Residents are encouraged and supported to organise and facilitate activities in and out of the facility for example the facility shop, regular knitting club, group cooking events and visits to and from other facilities. Residents who do not understand English and/or English is their second language are supported by different members of the community who affiliate with the same culture/language and cultural groups who visit the facility on a regular basis.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings 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>                                 | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaint forms are available in the foyer and from the nurses' station at any time.</p> <p>The complaints register reviewed showed that eight complaints have been received since the new owners have taken over in March 2017. For all internal complaints, actions taken, through to an agreed resolution, were documented and completed within the timeframes required. Action</p>   |

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|   |           | <p>plans showed any required follow up and improvements have been made where possible. The facility manager and owner/directors are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Five of the eight complaints sighted were verbal complaints which have been documented by staff and documented follow up was completed.</p> <p>One external complaint, received from the Auckland District Health Board (ADHB) in September 2017, has a corrective action plan in place and is due to be reviewed on 28 February 2018. The facility is able to show that they are meeting the requirements of the action plan. There have been no other complaints received from external sources since the previous audit.</p>                       |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery<br/>Consumers are informed of their rights.</p>  | <p>FA</p> | <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in two different areas of the facility, the Code pamphlets are available and in different languages representing all nationalities of residents who currently reside at the facility. Information is provided to support suggestions being made and/or complaints, and feedback forms are available.</p>   |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br/>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, or share a room with another person with both the residents' consent and consent of their family at the time of admission. There are four private lounge areas and outside areas that residents, families and visitors can easily access.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural,</p> |

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|  |    | <p>religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>The facility manager interviewed stated that there are currently no residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a current Māori health plan that supports the Te Whare Tapa Wha model developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff in the facility who have also provided activities and supported Maori culture week with residents.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>           | FA | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, meals and the need for same gender staff to support a resident with their personal cares. The resident satisfaction survey confirmed that individual needs are being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. 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.</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 evidence based policies, input from external specialist services and allied health professionals, for example, wound care specialists, a psycho-geriatrician and mental health services for older persons, physiotherapist, and education of staff. The general practitioner (GP) confirmed the service</p>   |

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|   |    | <p>sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</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>Residents and family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>At the time of audit there were two residents unable to understand English and one resident where English is their second language. Staff know how to access the interpreting service, although reported this was rarely required due to staff able to provide interpretation, knowing the residents well and understanding/speaking simple phrases, and as and when needed, the use of family members. Family interviewed stated that they are not concerned with the language barrier and that their relatives were 'looked after very well'.</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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. The updated business plan draft for 2018 was sighted at the time of audit.</p> <p>A sample of monthly reports to the owner/directors showed adequate information to monitor performance is reported including quality data, complaints, emerging risks and issues. As the owner/directors work in the business they are kept very well informed of any issues that arise at the time they occur. One owner/director manages the non-clinical areas of the business, including finances, as they are a registered accountant, and the other owner/director is a registered nurse with 10 years' experience in nursing in New Zealand, they assist and oversee clinical management.</p>  |

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|  |    | <p>There is a newly appointed facility manager who holds relevant qualifications and has nursed for over 25 years with their most recent experience being in aged care. They oversee the day to day management of the services provided and have been in the role since December 2017. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education related to aged care and relevant clinical practice.</p> <p>The service holds contracts with ADHB for rest home, hospital, respite, chronic health conditions and interim care services. Thirty residents were receiving services under the Age Related Residential Care contract (20 hospital, nine rest home and one respite care), one resident was receiving services under the Long Term Chronic Care contract and five residents were receiving care under the Interim Care Scheme Service contract at the time of audit. (Residents who receive care under the Interim Care Scheme Service contract enter the facility with a plan of care which is developed and overseen by a staff member from ADHB interim care services. (Residents can stay for a maximum of six weeks under this contract).</p> |
| <p><b>Standard 1.2.2: Service Management</b></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>When the owner/directors are absent, the non-clinical areas are overseen by the kitchen operation supervisor and clinical issues are managed by the facility manager. When the facility manager is absent, the senior registered nurse on the floor will carry out all the required duties under delegated authority with input from the owner director who is an experienced registered nurse and is able to take responsibility for any clinical issues that may arise.</p>  |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>                         | FA | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wound care management.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly staff meeting. A monthly analysis report is undertaken for all</p>   |

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|  | <p>data reviewed and presented to the owner/directors. The quality data is presented using trending from previously collected data from the facility. Staff reported their involvement in quality and risk management activities through audit activities and corrective action follow up. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Internal audit results are followed up and used to improve services as required. One example related to the October 2017 'Resident Rights' audit. It was identified that enduring power of attorney was not always identified. Appropriate corrective actions are documented and a follow up identifies that now all resident information related to enduring power of attorney has been obtained and updated. The corrective actions are signed off by the previous facility manager. Residents' files reviewed all contained appropriate information.</p> <p>Resident and family satisfaction surveys are completed annually (July/August 2017) with a separate food service survey being undertaken annually (August 2017). The most recent survey showed that most areas of service are satisfactory. One issue raised related to laundry going missing. The corrective action taken resulted in all residents being provided with individual laundry bags for personal clothing. Residents interviewed confirmed that the laundry services have improved. Staff also stated this has been a very good quality improvement. The food survey identified that for some residents the food is not hot enough. Appropriate corrective actions were put in place and a re-audit of food services in November 2017 gained a 100% satisfaction rating. Residents who like their food very hot have it heated in a microwave just prior to be given to the resident. Other residents stated their food is presented at a suitable temperature. (This was verified by food temperatures sighted. However, this does not occur every day, refer comments in criterion 1.3.13.5).</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The service continues to update policies to reflect the actions required by the new owners. This process is time-lined, and as stated by the facility manager, it will be completed in March 2018. All updated polices are discussed at staff meetings as</p> |
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|   |    | <p>verified in meeting minutes sighted. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. A list of all known risks and the actions taken to mitigate the risks is on public display in each area of the facility.</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> | FA | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner/managers monthly using a detailed analysis report which covers falls, hospital admissions, medical events, skin tears, bruises and near miss events. This information is presented using comparative data with other previously collected data and is also presented at staff meetings. This is confirmed by staff during interview. Adverse event information is used to improve services as appropriate and this is clearly documented. One example relates to the identification that some skin tears were due to the incorrect use of the hoist. Corrective actions included additional staff education, updating staff training by a physiotherapist on the correct use of the hoist, all resident lifting plans were reviewed and updated by the physiotherapist and staff were reminded of the need to moisturise residents' skin to prevent it getting dry. Staff confirmed that all actions have been fully implemented into everyday practice.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of non-facility acquired pressure injuries made to the Ministry of Health (November 2017 grade 4 and September 2017 unstageable), since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications (eg, public health) known to the current owner/directors.</p> |
| Standard 1.2.7: Human Resource Management   | FA | Human resources management policies and processes are based on  |



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| <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>  |           | <p>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 all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period. The annual staff performance appraisals were all up to date. The RNs annual competencies are based on the Nursing Council of NZ competencies for registered nurses.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. All staff education was clearly documented and each staff member had an individualised training page showing what they have attended and the length of time taken to do so. 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. (This is reflected in the pay scales for healthcare assistants of which there were 10 who have commenced but are yet to complete their papers for New Zealand qualifications, four level two, one level three, and five level four). Regular education sessions are presented by the gerontology nurse specialist from ADHB and/or members of the interim care team from ADHB along with guest speakers.</p> <p>There are sufficient (three) trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training. (Refer comments in criterion 1.3.3.3 related to completion of interRAI assessments which are not up to date).</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <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. Policy identifies that the facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff</p>  |

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|  |           | <p>available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Bureau staff are used when required. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage. The interRAI acuity levels information is used to ensure the mix and number of staff cover all residents' needs.</p> <p>The healthcare assistants work 12 hour shifts and the RNs work 8 hour shifts. Two activities coordinators cover seven days a week 9am to 5pm. There are two staff on duty in the kitchen seven days a week covering 7am to 6pm. Dedicated cleaning staff work six days a week.</p> <p>The facility manager works eight hour shifts, four days a week and shares the on call with the owner/directors. The business manager owner/director works at the facility full time and the registered nurse owner/manager works at least four days a week but is not shown on the roster. She works as an extra staff member and assists clinically if required. This was confirmed during RN interviews.</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> | <p>FA</p> | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system which is currently under review by the new provider.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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</p>                    | <p>FA</p> | <p>Residents enter the service for long term care when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Residents entering the service under the interim care scheme are admitted</p>  |

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| <p>services has been identified.</p>   |           | <p>between one to six weeks and assessed by the interim care clinical team as to their requirements and level of care. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC or GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate documentation and communication between the GP, facility, family and local hospital. The resident and family reported being kept well informed during the transfer of their relative.</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 medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the</p>   |

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|   |                        | <p>prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly and as requested.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There is one resident who self-administers medications. The resident at the time of audit did not have the medication they receive each evening by staff stored securely in their bedroom. By the end of audit this medication was secured in a locked box. Up to date documentation of competence was sighted for the resident self-administering medication. There is an implemented process for comprehensive analysis of any medication errors.</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>PA<br/>Moderate</p> | <p>The food service is provided on site by a qualified chef (newly appointed), cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>Not all aspects of food procurement, production, preparation, transportation, delivery, storage and disposal complied with current legislation and guidelines. Dry stores were found not to be stored as per requirements. A template for food temperatures, including for high risk items was sighted showing monitoring of food temperatures, but this was not always recorded. In viewing the kitchen, some of the appliances and structures (eg, walls and ceiling) required maintenance and cleaning. There was a cleaning schedule, however there was no evidence of daily</p>  |

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|  |        | <p>sign of.</p> <p>The facility was informed at the time of audit about the requirements for an approved food safety plan and final submission date of March 2018. Both the chef and cook have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys (please refer to criterion 1.2.3) and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. An example of this occurring was discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>  |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | PA Low | <p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning initially when the resident is admitted. The sample of care plans reviewed had an integrated range of resident-related information. Sighted in each resident's room is a mobility and transfer care plan created by a physiotherapist who sees all residents as required. InterRAI assessments are completed by one of three trained interRAI assessors on site; however, not all residents had an up to date interRAI assessment, nor have been seen by a GP (see criterion 1.3.3.3), or have an initial nursing assessment or supporting care plans. Residents under</p>  |

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|   |    | the Interim care scheme service (ICSS) are admitted with an existing care plan provided by the district health board. Residents and families interviewed confirmed their involvement in 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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was 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, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is provided seven days a week and provided by a trained diversional therapist holding the national Certificate in Diversional Therapy and is supported by an activities co-ordinator.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents of all ages. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day</p> |

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|   |    | discussions, residents' meetings, satisfaction surveys. Residents interviewed confirmed they found the programme interactive and fun and looked forward to the different day to day planned activities provided and support available to continue to be included as part of the community.   |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | FA | <p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>Residents are supported to access or seek referral to other health and/or disability service providers of their choosing. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to gerontology and wound clinical nurse specialists. The resident and the family/whānau are kept informed of the referral process, as was verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>     |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>                      | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. 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 interviewed knew what to do should any chemical spill/event occur.</p>   |

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|   |        | There is provision and availability of protective clothing and equipment (PPE) and staff were observed using this. Staff confirmed the use of PPE is not restricted and readily available.   |
| <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>  | PA Low | <p>A current building warrant of fitness which expires on 23 July 2018 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. However, some maintenance issues were identified during audit which are not shown in the maintenance requests.</p> <p>The testing and tagging of electrical equipment was undertaken in April 2017. Calibration of bio medical equipment was current as confirmed in documentation reviewed - this was undertaken in July 2017. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents and families were happy with the environment.</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     | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes eight bedrooms with full ensuite facilities and there are two ensuite bathrooms being shared between two rooms. There are separate staff and visitor toilet facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.   |
| <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>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are four bedrooms with two beds, and one three bedded room. All other bedrooms are single occupancy. Where rooms are shared, approval has been sought from the resident and family members. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> <p>It was noted that owing to the older part of the building having narrow</p>  |



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|  |    | corridors, the ambulance gurney could not be taken to the residents' bedrooms but ambulance staff managed using a transfer chair. This was observed during the days of audit.  |
| <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 | <p>Communal areas are available for residents to engage in activities. There are four lounge areas and three dining areas which all enable easy access for residents and staff. There is a lift which operates between the two levels of the facility. Residents were observed eating and undertaking activities outdoors. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs as confirmed during interviews.</p>   |
| <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>Laundry is undertaken on site in a dedicated laundry by healthcare assistants. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Refer to comments in standard 1.2.3 related to issues identified with missing laundry, which residents confirmed has been addressed.</p> <p>There are designated cleaning staff who work 8am to 1pm six days a week. Healthcare assistants undertake cleaning the other day. Staff have received appropriate training in safe chemical handling which is provided by the company which supplies the chemicals to the facility. This was confirmed in staff interviews and in staff training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and monthly checks are undertaken by the chemical provider.</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 were displayed and known to staff. Disaster and civil defence planning guides direct 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 updated and approved by the New Zealand Fire Service on the 06 November 2006. A trial evacuation takes place six-monthly by an approved provider with a copy sent to the New Zealand Fire Service; the most recent being on 13 November 2017. The orientation programme includes fire and security</p>  |

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|   |           | <p>training. Staff confirmed their awareness of the emergency procedures.</p> <p>The annual fire equipment check was carried out in November 2017 and identified that one fire hose was not working. The owner/director said they were not made aware of this and a plumber corrected this on the days of audit.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's are available to meet the requirements for the number of residents at the facility. Emergency lighting is regularly tested.</p> <p>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. The internal audit of call bells undertaken in June 2017 identified seven rooms that did not have working call bells. This was rectified and signed off by the facility manager. All bells checked at the time of audit were working.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time as part of the afternoon staff duties. Staff reported they feel safe at the facility.</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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by gas wall heaters in the hallways and heat pumps in common areas. Residents' bedrooms have fin-electric heaters. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from a nurse specialist as required. The infection control programme and manual are reviewed annually.</p> <p>The newly appointed facility manager/RN is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are</p>  |

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|  |    | <p>reported and discussed monthly at full staff and management meetings.</p> <p>The senior manager/RN interviewed stated that visitors suspected of being unwell are encouraged not to visit the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</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 IPC coordinator has appropriate skills and knowledge and has been in this role for two months. Further education in infection control is planned for 2018. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in November 2017 and include appropriate referencing.</p> <p>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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their</p>  |

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|  |    | room if they are unwell and increasing fluids during hot weather.   |
| <p><b>Standard 3.5: Surveillance</b></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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to staff and the management team. Benchmarking does not currently occur.</p> <p>Infection rates for the facility remain low despite several residents who have frequent infections due to current co-morbidities. Care plans evidence appropriate interventions and evaluations, individual and specific to the resident.</p>   |
| <p><b>Standard 2.1.1: Restraint minimisation</b></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. The restraint coordinator (facility manager/RN) provides support and oversight for restraint management in the facility, should it be put in place. The restraint coordinator is aware of the policies and procedures and their role and responsibilities related to restraint and enabler approval and use and keeping the register up to date.</p> <p>On the day of audit, no residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. One resident uses a chair lap belt and two residents have bed side loops to assist them to get out of bed independently. Monitoring of the safe use of enablers is undertaken daily and a six monthly review occurs as part of the resident's interRAI assessment. A review of incidents and accidents is included in the review process. There are no recorded incidents or accidents related to the three residents with enablers. Two residents' files reviewed related to</p> |

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|  |  | <p>enablers confirmed the use of enablers was shown on the resident's care plan and signed consent for the use of enablers was gained prior to use.</p> <p>Restraint and enabler information is discussed at monthly staff meetings as part of quality data which is shared. Staff interviewed are aware of how to safely manage both restraints and enablers and annual education is presented which includes management of challenging behaviours. This was last presented on 30 June 2017.</p> |
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## Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome  | Attainment Rating         | Audit Evidence   | Audit Finding  | Corrective action required and timeframe for completion (days)   |
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| <p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p> | <p>PA</p> <p>Moderate</p> | <p>The facility has a very low infection rate, and on observation, the kitchen appeared clean (below head height). The residents and families interviewed stated that they were happy with the meals provided.</p> <p>The cook interviewed stated that they clean the kitchen on a daily basis, including appliances, and was able to show evidence of a cleaning schedule, that food temperatures are taken prior to meals being delivered to residents, and was able to show evidence of a temperature template. However, there was no evidence that the cleaning schedule was being implemented and not all food temperatures were recorded. The oven and chip fryer require cleaning, however the staff interviewed stated they find this difficult as the extractor fan above</p> | <p>Over a 31-day period for December 2017, six days did not have completed food temperatures.</p> <p>The freezer in the kitchen did not have food labelled and dated.</p> <p>There was no evidence of the documented cleaning schedule being signed of as completed.</p> <p>Dry stores (potatoes) were sitting directly on the floor.</p> <p>Kitchen walls, ceiling (above head height) require cleaning and some maintenance. The oven and chip fryer require cleaning.</p> <p>The extractor fan above the oven is not working and the dishwasher is not always functional.</p> | <p>Provide evidence that all aspects of food storage, cleaning and maintenance of the kitchen environment and equipment meets current legislation and guidelines.</p> <p>30 days</p> |

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|  |        | <p>the oven is not working, and the dishwasher is not always functional.</p> <p>The cook and chef interviewed stated that they rotate their food (both frozen and dry) on a regular basis with regular ordering. All food in the fridges and dry stores were labelled and dated but food found in the freezer was not labelled or dated and several bags of potatoes were found sitting directly on the floor.</p>   |   |  |
| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | PA Low | <p>All but one resident (see criterion 1.3.4.2) admitted to the facility had written initial assessments, short term and long-term care plans and evaluations provided within required timeframes, however, eleven (11) residents do not have an up to date interRAI assessment with four of the ten awaiting transfer of files from the NASC to the facility. One interRAI assessment was due in August 2017, four were due in September 2017 and two interRAI assessments were due in October 2017. The newly appointed facility manager interviewed is not familiar with interRAI nor the timeframes for a GP to see a resident. At the time of audit the facility manager contacted the NASC team via email and has requested transfer of the four files and is currently booked in to attend the management training for interRAI. The GP interviewed stated no concerns with the facility or the level of care provided by staff, however two of six resident residents admitted to the facility have not seen a GP within required timeframes. It was evident from staff interviewed that they knew the residents</p> | <p>Ten interRAI assessments are overdue. Four of the ten are awaiting transfer of files from NASC to the facility. One resident admitted from home was assessed by the facility GP five days after admission. One resident admitted from home on the 29 December 2017 has not been assessed by a GP at the time of audit, with GP documented notes stating 'new admission, awaiting old notes'.</p> | <p>Provide evidence that all interRAI assessments are up to date and that all residents are seen by a GP within the required timeframes to meet contractual requirements.</p> <p>60 days</p> |

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|  |        | well. Family/whanau interviewed stated that they were happy with the care and communication provided.  |  |  |
| <p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p> | PA Low | <p>Integrated progress notes in resident's files sighted showed individual and specific information and discussions related to the resident thus ensuring the resident's needs were met, which included communication with the family and supporting allied health professionals. This information was all evidenced in short and long-term care plans. The staff interviewed knew the residents well and this was also highlighted at handover. For one resident, all information had been gathered and documented in the progress notes, an initial nursing assessment had been commenced, but the only information documented was the EPOA contact details. There was no supporting short term or long-term care plan evidenced. The facility manager interviewed stated that there was no reason that the assessment had not been completed and a registered nurse has been asked at the time of audit to commence and complete this documentation. The resident was unable to be interviewed.</p> | <p>At time of audit, one resident admitted on the 20th November 2017 has not had an initial nursing assessment or care plan developed.</p>   | <p>Provide evidence that all residents have a nursing assessment undertaken.</p> <p>60 days</p>              |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>   | PA Low | <p>There is evidence of up to date electrical safety checks, regular checks for the maintenance of the building warrant of fitness by an approved provider and that medical equipment is checked annually. Flooring is secure. Whilst staff confirmed they understand the process for</p>  | <ol style="list-style-type: none"> <li>1. A Waitara Ave toilet window frame is rotten and needs to be repaired.</li> <li>2. The power plug in room 76 needs fixing as it is loose.</li> <li>3. The bathroom hand basin cabinet in room 69 has water damage and cannot</li> </ol> | <p>Provide evidence that all maintenance repairs required are identified and undertaken.</p> <p>180 days</p> |



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|  |  | <p>requesting day to day maintenance and that requests are followed up promptly by the owner/directors, three areas not shown in the maintenance book were identified during audit.</p> <p>Resident equipment is safely stored and movement around the facility is not restricted.</p> | <p>be cleaned to meet infection control standards.</p> |  |
|--|--|--|--|--|

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.