MA Healthcare Group Limited - Awanui Rest Home

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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity: MA HealthCare Group Limited

Premises audited: Awanui Rest Home

Services audited: Dementia care

Dates of audit: Start date: 11 May 2018 End date: 11 May 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 22

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

Awanui Rest Home provides dementia level of care for up to 24 residents in Mount Wellington, Auckland. On the day of the audit there were 22 residents. The service is managed by a facility manager who is an enrolled nurse (EN) with over 10 years' experience in aged care management. The facility manager (FM) is supported by the owner/directors, a diversional therapist (DT), a registered nurse (RN), and an external consultant. The service gained national recognition for being the first facility in New Zealand to achieve a silver Rainbow Seal for developing awareness and acceptance around diversity and inclusiveness for residents who identify as LGBTI.

This provisional audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess the level of conformity of the current provider prior to the facility being purchased. A certification audit was completed with the service on the 26-27 February 2018 and the consequent audit report was utilised as part of this provisional audit. The certification audit was conducted against the Health and Disability Service Standards and the organisations contract with the district health board (DHB). The audit process included the review of policies and procedures; sampling of

resident and staff files; observations; interviews with residents, residents' family members, management, staff, and a general practitioner.

The prospective purchaser is currently general manager of Lakeside group who currently own Elizabeth rest home. The purchaser has sent up an operations team to support the governance of Awanui. This includes another operations manager that currently owns a number of aged care facilities. It is the new owner's intention to facilitate a smooth transition at an operational level and to minimise disruption to staff and residents. There is a plan for the transition and change of ownership. It is intended for consistency to maintain the current policies and procedures and quality/risk management system. The prospective purchaser is not planning to make changes to management or staffing on purchase. With support by the current management team at Awanui, the new owner will maintain input at a governance/operational level and visit at least weekly to support the manager.

There are two areas that have continued to achieve a continuous improvement relating to the quality programme and staff education. There are two additional CIs achieved regarding the links maintained with family and improved resident safety.

The audit has identified one area requiring improvement. This relates to the process for signing off medication competencies.

Consumer rights

Management and staff ensure that care is provided in a way that focuses on the individual and maintains their privacy and dignity. Resident rights are maintained. The environment inside and outside of the rest home offers freedom of movement for all residents in a homely atmosphere with beautiful gardens and animals to interact with. Cultural needs are identified and met. Policies are implemented to support residents, family/whanau rights, communication and complaints management. Informed consent processes are appropriate to the type of care provided and the residents' needs. Care plans accommodate choices. There are processes to ensure residents are free from discrimination, abuse or neglect. A complaints register is maintained.

Organisational management

The prospective owner will remain at an operational level with support from an operations team. There are no planned changes to the current management team at Awanui.

The services' mission, vision and philosophy are clearly identified and recorded in the organisation's documents and published information. There is evidence that leadership is supported by a culture of empathy, kindness and compassion. Organisational performance is monitored by the directors.

The quality and risk management system is fully implemented. Policies and procedures reflect best practice. Quality improvements are embedded into the organisation and demonstrate continuous improvement. Quality data is analysed and improvements are evaluated. Organisational risks are identified. An adverse event reporting system is in place.

Human resource management processes for employment, orientation, and ongoing education for staff are in place. The facility manager is suitably qualified and supported by a registered nurse (RN). Staff numbers exceed minimum requirements.

Continuum of service delivery

Entry to service processes are in place with adequate information to communicate the services provided. Care plans are completed by the RN in consultation with the family, other nursing team members and other health providers. InterRAI assessments are completed for all residents within the required timeframes. Care plans are reviewed as required.

There is a wide range of planned activities that are flexible to meet the needs of individual residents. The diversional therapist completes the activities assessments with input from family and other nursing staff.

Medication management systems are in place. The service uses electronic medication system. Medication reviews are conducted by the general practitioners (GPs) within the required timeframes.

All food services are provided from the facility. Special dietary requirements are catered for when needed. Safe food/fluid management processes are in place.

Safe and appropriate environment

The building has a current warrant of fitness and emergency evacuation plan. Maintenance is both proactive and reactive. There is sufficient space to allow movement of residents throughout the facility. The facility is designed, both inside and out, to provide a calm, unrestricted, and safe environment for residents to wander freely.

There is sufficient lounge and dining areas throughout the facility. The indoor areas are able to be ventilated and heated adequately. The outdoor areas are safe and easily accessible. Cleaning and laundry staff provide safe and appropriate services.

There are planned and implemented strategies for emergency management.

Restraint minimisation and safe practice

Restraint minimisation processes are in place. Staff demonstrated knowledge on the restraint use minimisation and safe practice policy and alternative methods that may be used. All staff have received education on challenging behaviour management. The service is a secure facility with environmental restraint in place.

Infection prevention and control

There are systems in place to minimise and prevent cross infection to residents, staff and visitors. The infection control policies and procedures give clear guidelines on the infection control processes. Infection control data is collected, analysed, acted upon, evaluated and reported in a timely manner. There have been no infection outbreaks reported.

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	1	43	0	0	1	0	0
Criteria	4	88	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumers Rights (the Code) poster is displayed in the RN office, which is visible to all residents and family through large open window. Staff files reviewed confirmed the Code is covered in staff orientation and through on-going education. Staff interviewed confirmed knowledge of the Code. The Resident's Rights policy and procedure outlines the Code and how it is incorporated into everyday practice. Interactions observed between staff and residents demonstrated implementation of the requirements of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	An informed consent policy is in place. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment. However, in most instances, consent was signed by family due to residents having dementia. Informed consent is closely linked with the policy and procedure document. Residents' files sampled confirmed consent forms are signed (and wishes for life sustaining treatment completed by family). Family members interviewed confirmed they were

		involved in care planning and are actively encouraged to be involved in decision making. Residents files sampled had enduring power of attorney elected and activated. There is a process for gaining family consent in the event a bedroom is shared. Staff interviewed acknowledged the residents' rights to receive, refuse, and withdraw consent for care. Staff demonstrated knowledge regards the management of challenging behaviour.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The policy and procedure document references resident's rights to access, and the contact details of advocacy services, cultural services, and spiritual advocates. The policy and procedure document, the admission agreement, and the client information brochure also lists the contact details for the Nationwide Health and Disability Advocacy Service. The policy and procedure document advises of the residents' right to independent advice and support. Family members interviewed confirmed they had received information regarding access to advocacy services via the information brochure and the pre-admission pack. Family are encouraged to involve themselves as advocates. Advocacy brochures are available in the office. Relevant education for staff is scheduled. Staff interviewed confirmed their understanding of residents' rights to advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	There are no set visiting hours and family are encouraged to visit; as confirmed by family interviewed. Residents are supported and encouraged to partake in the planned activities programme as per their care plan. This was confirmed in residents' records sampled. Family members interviewed confirmed their involvement in all aspects of residents' care. Data showed that family were not brining young children to visit residents. A child friendly playground was built and communicated to

		families. Outcomes have been reviewed and an increase in young visitors has occurred. Staff and families interviewed confirmed more children are being brought to visit the residents. Residents have responded well to the increase in visits from young children. Accordingly, a continuous improvement rating has been allocated to 1.3.7.1 “Planned Activities”. The increase in the number of younger people the DT reports improvements in residents’ behaviours.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A policy and procedure is attached to every admission agreement and is in line with Right 10 of the Code. The procedure provides details regarding how to make a complaint, who to make a complaint to and includes contact details, time-frames for responding, and how to access advocacy services. A complaints register is maintained. All complaints are managed by the FM. Management stated that no complaints have been received since the last audit. A review of the quality process confirmed that the complaints process is integrated with the quality programme. Management reported that there have been no investigations by the Health and Disability Commissioner (HDC), Ministry of Health, the Accident Compensation Commission (ACC), police or coroner since the last audit. Review of staff meeting minutes confirmed that complaints are a permanent agenda item. Staff interviewed confirmed their knowledge of the complaints process. Family interviewed confirmed they understand their right to complain.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information for new residents, family, and friends, in relation to the Code, is in the pre-admission pack, admission agreement, and information brochure. This information includes accessing advocacy services. In interview, family members confirmed their understanding of the Code. The prospective new co-owner understands the Consumer Rights, as he

		is currently working as an operations manager for another aged care facility
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Processes implemented by management and staff ensure the residents right to privacy and dignity are recognised and respected at all times. Residents adorn their rooms with personal belongings. There was one double room with single occupancy Services are provided in a manner that maximises each resident's independence. Information from the activities assessment guide, guides care planning around activities the resident previously enjoyed. The manager's office is designed as a shop where residents can wander in and out for the purpose of providing a sense of normality with no restrictions. No confidential documents or information is accessible in this office. Policy defines abuse and neglect, references legislation, and provides instruction on dealing with suspected or alleged abuse and neglect. Staff receive education regarding abuse and neglect. Staff interviewed verbalised the actions of everyday practice to ensure residents are treated with respect and privacy whilst encouraging independence. All family interviewed where positive with the high level of respect afforded to the residents by staff and management. Values, beliefs, and cultural needs are met by the service. This was evidenced by care planning sighted.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual's customs and beliefs, as well as the cultural and ethnic backgrounds of Maori, are valued and fostered with in the service. Staff value and encourage the participation of family /whanau in daily care of the residents. Cultural values and beliefs are documented in the residents' care plans, which are personalised for the 6 Maori residents. Staff receive education on cultural awareness in their orientation and are aware of the importance of whanau in the delivery of care for Maori residents. There is access to interpreter services and residents'

		information is available in Maori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Through the activities assessment guide document, family provide information pertaining to the resident's values, beliefs, and cultural requirements prior to dementia. This information is used for planning care and diversional activities. All families interviewed confirmed they were involved in the development of the residents' care plan. Staff interviewed confirmed Awanui Rest Home's philosophy of assisting all residents to maintain their independence.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Code of conduct/house rules define professional boundaries and are discussed and signed by any new employee during their orientation process. Interviews with staff confirmed their understanding of professional boundaries. Staff demonstrated care and compassion towards the residents. Families interviewed did not express any concerns related to staff breaching any professional boundaries. Previous and current training plans sampled confirmed there is ongoing education regarding discrimination which is reflected with the Silver Rainbow Seal.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures which guide staff actions are linked to evidence-based practice and are referenced accordingly. A RN is available onsite five days per week. Three general practitioners (GPs) visit the facility and review residents at a minimum of three monthly. A van is available for regular outings. Residents are encouraged to remain active and have personalised activities. All residents and families interviewed expressed their satisfaction with care delivery. The GP interviewed indicated confidence in the services being delivered and would engage the services for a family member if needed. All staff files sampled confirmed staff receive education in dementia care.
Standard 1.1.9: Communication	FA	Staff were observed communicating effectively with residents and their

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		families. Open disclosure policies outline the way in which information is to be provided to the residents and families. The information brochure provides a comprehensive range of information regarding the services provided. The admission pack gives comprehensive information regarding the scope of the service including services requiring additional fees. Family are involved in an annual resident's review. There is evidence that informal communication with family members occurs regularly. Families are kept informed of any incidents, accidents, or change in the resident's health care status. This was confirmed through a sample of clinical files. Access to interpretive services are available but has not been required. Review of staff files confirmed that staff education on interpreter services available is covered during orientation. Evidence of families being informed is documented in the residents' files. Family members interviewed confirmed they were kept well informed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Awanui Rest Home is privately owned by two directors and provides dementia level of care under the aged residential care agreement (ARC). It is a specialised secure unit for up to 24 residents. There were 22 residents on the day of the audit, one of whom was under 65 years of age. The manager informed that no other level of care was provided. All but one rooms is for single occupancy. On the day of the audit the double room had single occupancy. The service has a current business plan (2018-2019) which identifies the objectives and goals of the service. A mission statement, philosophy, and objectives are in place and reflect a resident centred approach. The core value 'living well with dementia' is stated on entrance sign. The manager is an enrolled nurse (EN) with a current practicing certificate. The manager has responsibility for operational matters and reports to the directors monthly, or more often if needed. Additional professional advice is sought from Care Association NZ and an external contractor. The manager is supported by a RN who works five days a week and has additional RN support from the owners' other two facilities. The manager attends over eight hours of professional

		education a year. The manager's roles and responsibilities are clearly defined in the position description. Interviews with family confirmed that the service meets the high level of care needed for their family members. Management and staff reported sufficient staffing, resourcing, and equipment to provide care. The prospective purchaser is currently general manager of Lakeside group who currently own Elizabeth rest home. The purchaser has sent up an operations team to support the governance of Awanui. This includes another operations manager that currently owns a number of aged care facilities including providing dementia level care. It is the new owner's intention to facilitate a smooth transition at an operational level and to minimise disruption to staff and residents. There is a plan for the transition and change of ownership. It is intended for consistency to maintain the current policies and procedures and quality/risk management system. The prospective purchaser is not planning to make changes to management or staffing on purchase. With support by the current manager and registered nurse at Awanui, the new owner will maintain input at a governance/operational level and visit at least weekly to support the manager.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	Appropriate procedures are in place to ensure operation of the service continues in the absence of the FM. The FM role is undertaken by the diversional therapist (DT) or RN should there be a temporary absence of the FM. The DT and RN confirmed they are responsible for the day to day operations of the service should the FM be absent. Staff interviewed confirmed service provision is undertaken in a timely, appropriate, and safe manner.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous	FA	The service implements quality and risk processes, as described in policy, to ensure all aspects of service delivery are monitored. Staff confirmed during interviews that they understand the quality processes. Quality and risk management systems include: internal audits;

quality improvement principles.		complaints management; incident and accident reporting; health and safety; and infection control reporting and analysis. The FM collects and collates data including: falls; restraint use; pressure injuries; wounds; and medication errors. Results are communicated at staff meetings or more frequently if corrective actions are needed. Corrective actions are documented in the staff meeting minutes and reviewed frequently until closed. Where additional resourcing is required, support and input from the directors is accessed. Benchmarking occurs against previous months data. An annual quality and statistics report is produced. All policies and procedures are reviewed and up to date. Policies aligned with current good practice and service delivery and meet legislative requirements. This includes identification of the interRAI assessment tool to inform care planning. A document control process is in place and is current. There is a process for the management of obsolete documents. Organisational risks are identified and minimised. There is a hazard register that identifies health and safety risks as well as risks associated with: human resource management; legislative compliance; contractual risks and clinical risk. A health and safety manual is available and includes relevant policies and procedures. The prospective owner advised on interview that policies and procedures and the current quality and risk management system will remain in place.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse, unplanned or untoward events via the accident/incident forms. The incident and accident forms are reviewed and signed off by the FM and collated and reported on a monthly basis. There is an open disclosure policy. Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse event reporting. Family members interviewed confirmed that information provided to them regarding adverse events was in line with the principles of open disclosure. The FM understands the statutory and regulatory obligations

		in relation to essential notifications to the correct authority. Three notifications have been made to the Ministry of Health (MoH) since the last audit. One was in relation to a resident leaving the property unattended, one was in relation to a wound, the other was regarding a change of RN. No further actions were required. Samples of incident/accident forms, confirmed that data is analysed and corrective actions implemented. Trends are identified and feedback at staff meetings and handover.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with: employment agreements; reference checking; completed orientations; and competency assessments. Copies of current annual practising certificates were sighted for all staff that require them to practice. The FM and an external advisor are responsible for the in-service education programme. Competency assessment questionnaires were available and completed competencies were sampled. All staff have received training in challenging behaviour and dementia care and have either completed or commenced the Career Force education modules. Annual education plans were viewed. All the 2017 education was delivered and the 2018 education plan being commenced. Staff files provided evidence that all staff complete an orientation programme and have annual appraisals. The RN has completed interRAI training. Kitchen staff have completed safe food handling training. The previous continuous improvement rating remains regarding the education programme provided to all staff in order to gain the Silver Rainbow Seal, which is in recognition of commitment to providing a safe, inclusive environment for residents who identify as LGBTI.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing levels are based on the needs of the residents. Staffing levels exceed contractual requirements. The FM is responsible for rostering. Full weeks rosters sampled confirmed staff are replaced if unavailable. Staff confirmed there are adequate staff on each shift to meet the needs of the residents. The FM and DT work Monday to Friday. There are dedicated kitchen, laundry, cleaning, maintenance, and garden staff. A RN is on duty five days a week. RN cover is available on an on-call basis at all other times. As part of the philosophy of the service, staff are encouraged to interact with residents and assist in providing meaningful activities for the residents. For example, residents were assisting with gardening and preparation of vegetables for meals. Family interviewed confirmed staffing levels were adequate to provide safe care. Details of staff rationale and skill mix are documented in policy. The prospective owner confirmed on interview there are no planned changes for staff or the roster and all staff are planning to stay on with change of ownership.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' name, date of birth, and the National Health Index (NHI) number are used as unique identifier on all residents' information sighted. Clinical notes sampled were current and accessible to all staff and in an integrated file. On the day of the admission all relevant information is entered into the resident's file by the RN following an initial assessment, and by the doctor when they visits. The files are kept secure in the RN's office. No personal or private information was observed to be on display on the days of the audit. Archived records are safely stored on site in a locked store shed for 10 years. These are catalogued and easily retrieved. Obsolete records are destroyed through document destruction services.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for	FA	Information about the facility and services provided is clearly documented in the admission pack, facility brochure, information packs and the facility website. Residents are admitted according to their assessed needs through the local district health board and needs

services has been identified.		assessment service. Entry to services is managed by the FM and the RN. Information about the facility and services provided is clearly documented in the admission pack, facility brochure, information packs and the facility website. Residents are admitted according to their assessed needs through the local district health board and needs assessment service. Entry to services is managed by the FM and the RN.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Residents' family are advised of transfers to and from the facility. Yellow envelopes are utilised when transferring residents to and from the local DHB. All necessary information to ensure safe transfer and continuity of care is included in the yellow envelope at time of transfer. There is use of phone calls and discharge letters to ensure appropriate handover of the residents' needs. Records of referral documents were sighted in the resident files sampled.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The facility uses an electronic medicine management system. There is e-prescribing, dispensing, administration, review and reconciliation of medicines. Medication is stored safely in locked cupboards. The RN and medication administration competent health care assistants (HCAs) are responsible for the keys to the medication cupboards. No expired medication was sighted on the days of the audit. A process for returning unwanted medicines is in place and documentation was sighted. Three monthly medication reviews are completed by the GPs as required. There are no residents who self-administer their medication. HCAs receive medication administration training. Two HCAs were observed on audit days administering medication and safe practice was witnessed. Corrective action is required regarding the sign off process for medication administration competencies as these have not been signed off by a registered nurse.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All food services are provided from the facility. Kitchen staff are notified of dietary requirements of new residents by use of a diet profile form. A nutrition requirements form is compiled and updated by the FM or RN and provided to the kitchen staff. Residents' likes/preferences, dislikes and allergies are identified on the nutrition requirements form. Special diets are provided as required. Residents have access to food and fluids over the 24-hour period. There are processes in place to manage cleanliness of the kitchen and the food storage areas. The kitchen and pantry were clean on audit days. The dry goods in the pantry were labelled with date of delivery and there was no expired food sighted. There is an ordering/procurement system in place. Food, fridge and freezer temperatures are monitored and recorded as per organisation's policy. The fridge was clean and well packed. Left- over food was dated. The kitchen staff have food handling training. All services in the kitchen comply with current legislation and nutrition guidelines.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	Where a referral or entry to service is declined, the FM communicates with the referral agency for appropriate or alternate services to ensure safety of the consumer. The family/whanau is advised of the reason for the decline.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Initial nursing assessments are completed by the RN on admission. Initial medical examinations are conducted within 48 hours of admission. InterRAI assessments and care plans are completed within three weeks of admission with input from the families and other health team members. All identified needs in the assessments were addressed in the care plans sampled. Residents' preferences are included in the care plans as sighted in the sampled files.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused,	FA	Residents' files sampled confirmed that care plans have detailed support required and/or interventions to achieve desired outcomes. Care plans

integrated, and promote continuity of service delivery.		are comprehensive and include both physical and non-physical needs. Individual goals are documented. Care plans demonstrated service integration with other members of the health team. Ongoing assessment process is conducted and interventions altered as required.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	In the files sampled, interventions are adequate and appropriate to meet the assessed needs and desired outcomes. The interventions are updated when required. The interRAI assessment triggered areas were addressed in all the files sampled. All residents have interRAI assessments completed. The GP interviewed reported that there is good communication with the nursing team and there is prompt follow up of prescribed treatments. In interview, staff reported that there are adequate resources to provide quality care for the residents.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The activities programme has been given a continuous improvement rating as improved outcome for residents is evidenced by more active participation. Residents are involved in a variety of activities which help them to relive their earlier life skills and interests.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care plans are evaluated by the RN at least six monthly or when there are significant changes. Input is sought from the multidisciplinary team including the DT, family, nursing team, GPs and other health providers involved in the residents' care. Sampled files confirmed that updates showing progress towards desired outcomes are documented on the long-term care plans or short- term care plans and changes of interventions are actioned where progress is different from expected.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided	FA	The FM, RN and the GPs facilitate residents to access other health and or disability services by referring residents and or appointed family to the appropriate service required. In interview, family members reported that they are advised of the choices and options to access other health and

to meet consumer choice/needs.		disability services where indicated. Records of the referral process to external services was sighted in the residents' files sampled.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There is an effective system of waste management in place. Chemicals are supplied by an external contractor and stored securely throughout the facility when not in use. Additional chemicals are stored in a separate locked shed. Appropriate policies are available, along with material safety data sheets. The external supplier provides education on chemicals provided. Education records sampled confirmed staff attendance at training. There is appropriate signage in kitchen and laundry regarding chemical storage and hazards. There is personal protective equipment available for use by staff and this was in use on the day of the audit. Staff interviewed were knowledgeable about chemical safety and disposal of continence products.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness which expires on 29th November 2018. The FM stated there has been no building modifications since the last audit. The home employs a full-time maintenance person and a gardener. There is a proactive and reactive maintenance plan in place. All areas sighted were well maintained. Water temperatures are monitored and recorded. Electrical testing and tagging occurs annually and was completed in 2017. There is a hazard system in place to ensure physical environment minimises risk of harm as well as promotes safe mobility and aids independence and is appropriate to the needs of the residents. Clinical equipment is tested and calibrated by an approved provider at least annually or when required, evidence sighted. Residents have adequate internal and external space and are free to move around as they desire. The facility's fence is obscured by the gardens and this provides a sense of freedom. The external space is safe for mobility and aids and promotes strolling in the garden. The facility has a van available for transportation of residents and also for residents to sit in at any time to help settle them. All drivers hold full drivers' licences and first aid certificates.

		In interview, family confirmed that the facility is fit for the purpose for their family members. Staff interviewed felt that the environment helps to reduce episodes of challenging behaviour. The prospective owner confirmed on telephone interview there are no environmental changes planned in the short term, apart from on-going maintenance and upgrades to furnishings and equipment as needed.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Toilet areas are in colours which are appropriate for residents with dementia. One resident and family members reported that there are sufficient toilets and showers. All resident rooms have hand basins. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All bedrooms are of a size which allows sufficient space for the residents and staff to mobilise with or without assistance in a safe manner. They are personalised to meet the residents' wants and needs and have appropriate areas for residents to place personal belongings. All but one room is single occupancy on the day of the audit, the double room had one resident.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has lounge and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The dining areas have ample space for residents.

Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Policies and procedures for both cleaning and laundry duties guide staff actions to ensure the facility remains hygienic and assist in the control of infections. Cleaning staff have completed cleaning chemical safety training. Dedicated cleaning staff maintain the documented daily cleaning schedules. The facility was observed to be clean and odour free. There are dedicated laundry staff seven days a week. The washing machines are serviced regularly and washing cycles are checked by the chemical providers. In interview, staff confirmed that they understand what each wash cycle is for and how to manage infectious linen safely. The methods, frequency and materials used for cleaning and laundry processes are monitored through internal audit. All internal audit reports confirmed this occurred. One resident and family confirmed they are happy with the laundry and cleaning services provided. The laundry, which houses, the cleaning cupboard is locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved evacuation scheme in place dated 16 December 1998, which remains applicable as there has been no modifications to the building. There is a comprehensive emergency management plan in place. The civil defence kits are kept in a locked shed outside. Review of these confirmed all equipment within its expiry date. The emergency water tank in the garden holds 800 litres. The emergency food supply is sufficient for three days for full occupancy and staffing. There is an emergency gas BBQ provided for cooking. Alternative light source is through large torches. The facility is secured at all times. Staff receive security training and are aware of when to call emergency services. Evidence of training was sampled on staff files. Emergency education for staff includes six monthly trial evacuations. The latest fire drill/evacuation was conducted

		in February 2018. Fire equipment is checked monthly by approved provider. Sprinkler and smoke alarms are in each room and are monitored through a central system. The call bell system has been replaced by sensor mats. Original call bells remain in bathrooms and toilets for staff to summons additional help if needed. Staff interviewed confirmed sensor mats work effectively.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All resident's bedrooms have at least one opening window for natural light and ventilation. The facility has heat pumps mounted on the walls in communal areas. Each bedroom has a panel wall heater. The environment was observed to be maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The FM who is an experienced EN, is the infection control coordinator. There is a documented infection control program in place to minimise the risk of infection to residents, visitors and staff. The infection control policy has clear guidelines on the responsibilities and clear lines of accountability for infection control. Infection prevention and control information is communicated to visitors, residents and other service providers by the use of posters or verbal conversation face to face or via the phone. There is a process in place for preventing/minimising cross infection between the service users, visitors and residents. There is an annual review of the infection control program and an annual report was sighted.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator (ICC) has the support of the RN, the GPs and external expert advice from local DHB when required. Regular internal infection control audits are conducted by the ICC. In interview, staff reported that there are adequate resources for effective implementation of the infection control programme.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Current good practice and relevant legislative requirements is reflected in the infection prevention and control policies and procedures. There is an infection control folder with policies and procedures in the nurses' station and is easily accessible for all staff.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control training is provided for all staff during orientation and in an ongoing manner. Infection control training records and competencies on hand hygiene for all staff were sighted. One on one or face to face education is provided to visitors per rising need. The ICC has received the external infection control training. Close monitoring and regular reminding where applicable is provided for residents to minimise cross infection. Staff were observed practising hand hygiene on audit days.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Monthly infection statistics are collected and collated monthly through internal audits. Benchmarking is completed month by month and year by year. The GP reported that they are consulted when there is suspected infection and prescribed treatment is actioned in a timely manner. Infection statistics are discussed in staff meetings and interventions to assist in prevention and reduction of infections are acted upon and evaluated as required. The type of surveillance is appropriate for the size of the facility. An infection control annual report was sighted and quality improvement plan rolling over from 2017 is in progress.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint coordinator is the RN. Processes for minimising restraint use and safe practice are in place. Types of authorised restraint are bedrails and lap belts but is not currently used for any client. The service is a secure facility with environmental restraint in the form of high fencing hidden by gardens and a locked coded gate with the keys displayed, where family go in and out as they please. Annual restraint minimisation training for all staff was completed and records of training were sighted. Restraint competencies for all staff were current.

		The prospective owner on interview was versed with his responsibilities in respect of restraint minimisation and safe practice. The new owner intends to support the manager and staff to remain restraint-free.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	During the audit it was noted that medication competencies for the RN had been signed off by the FM who is an enrolled nurse. This was corrected on the day by another RN from another facility (belonging to the owners of Awanui Rest Home) countersigning the competencies. However, no observations were undertaken by the other RN. Subsequent interview with the manager revealed that other medication competencies of HCAs were also signed off by the manager in the absence of a registered nurse for a period of three months.	The system for signing off medication competencies did not meet the required medication guidelines.	Provide completed medication competencies as per medication guidelines 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Quality data is collected, analysed and evaluated. The results are used to continually improve the service. For example, results from internal audits regarding falls identified the time where falls were occurring most frequently. An additional staff resource was added for the high falls time each day. A review of the corrective action was conducted through use of additional internal audits. This confirmed a decrease in falls.	The organisation has demonstrated achievements beyond expectations in regard to the corrective action process. Additional staffing resources provided have improved outcomes by undertaking hourly checks of all residents both indoors and outdoors, which are signed off at every shift. This has resulted in reduced falls on average by 1 or 2 a month.
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	CI	The organisation has appointed appropriate providers to safely meet the needs of the consumer. Internal audits raised concerns regarding two hourly checking of residents. Following internal audit recommendations, residents are now checked on an hourly basis and a record of this was viewed. These	The organisation has demonstrated achievements beyond expectations by monitoring and improving resident safety through competent staff.

		additional checks have resulted in decreased falls, thus increasing resident safety.	
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	The ongoing education for staff to provide safe and effective services to consumers continues to exceed expectations beyond this standard. With the programme there has been a documented review process which includes the analysis and reporting of findings to staff, management, owners and external recognition agency. Positive outcomes continue to be measured by the rest home.	The achievement of the quality improvement projects in the education programme for diversity and inclusion is rated beyond the expected full attainment which is reflected with Silver Rainbow recognition. Outcomes are identified through internal audits and satisfaction surveys that are completed annually. Positive comments made by staff and relatives about the achievement of the Silver Rainbow Seal (SRS) has had a positive impact on staff who are now more open in discussing sexuality and understanding residents who identify as LBGTI. To maintain the SRS the organisation is reviewed on a 2-yearly basis to ensure training and attitude.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	There are individualised activities plans for each resident that take into consideration residents' needs, age, culture and setting of the service. Individual 24-hour activities plans were sighted in sampled files. The activities assessments are completed with input from the family through the activities assessment guide that the family completes on admission. The DT completes the activities plans. The activities plans are evaluated six monthly or as required. The residents' participation in activities is monitored and records were sighted in the progress notes. There is a wide range of activities including: beach walks for residents to absorb natural magnesium; one on one activities; hanging out washing; dusting; vacuuming; group talks; newspaper reading; crafts; reminiscing; quiz; dancing; video music; shopping and outings. There is a play area for children. In	The activities programme is improving outcomes for residents as evidence by more active participation and less (or minimal) behaviours of concern and reconnecting them with their previous skills thereby boosting self-esteem. Some activities whether passive or active are helping in improving resident's muscle coordination. The organisation has demonstrated beyond expectation with regard to increasing the links maintained with young family members. A notice was put up for family members to comment on the playground when it was ready to be used. Positive verbal feedback was also received from relatives approximately 3 months later. Further positive feedback was confirmed on the day of audit by relatives who were interviewed. The provider has added to the satisfaction survey to

		interview, a family member reported that this is an excellent way of accommodating those families with young children as they can visit and the children are kept occupied. Refer to 1.1.12.1. There is a chicken farm. One of the residents actively looks after the chook house. In interview, a family member reported that this idea makes the facility feel homely and they consider it as their second home. They were satisfied with the innovative ideas of the activities provided. The residents were observed participating in a variety of activities on the audit days.	enable receipt of ongoing feedback.

End of the report.