# Brujen Investment Trust - Kenderdine Park

## 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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| **Legal entity:** | Brujen Investment Trust |
| **Premises audited:** | Kenderdine Park |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 12 December 2018 End date: 13 December 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:** 26

# Executive summary of the audit

## Introduction

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

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

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| Indicator | Description | Definition |
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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

Brujen Investment Trust trading as Kenderdine Park provides rest home and hospital level care for up to 35 residents. (Five dedicated rest home level care and 30 dual purpose beds). Kenderdine Park is managed by the chief executive officer (CEO) who is the owner. She is assisted by a facility manager and a clinical nurse manager. 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 and a general practitioner.

This audit has resulted in a continuous improvement rating in relation to falls management. There were no areas requiring improvement.

## 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. |

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 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.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. 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.

## 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. |

Business and quality and risk management plans include the scope, direction, goals, and values of the organisation. Monitoring of the services provided to the CEO/owner is regular and effective. An experienced and suitably qualified team manage 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. 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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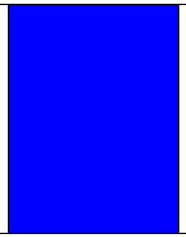
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |

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. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. 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. Food is safely managed. Residents verified satisfaction with meals.

## 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. | | Standards applicable to this service fully attained. |

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and medical 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. |

The organisation has implemented a no restraint policy. The environment was restraint free on the days of audit with no enablers or restraints in use. Should restraint be required there are appropriate assessment, approval and monitoring process identified in policy and procedures. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. 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. |

The infection prevention and control programme, led by an experienced and trained 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) |
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| **Standards** | 1 | 44 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| **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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | 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. |
| Standard 1.1.10: Informed Consent<br><br>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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care. The clinical nurse manager interviewed stated that advance care plans are discussed at the time of admission. At the time of audit there were two residents with an advance care plan in place. |

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| Standard 1.1.11: Advocacy And Support<br><br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | 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 are displayed and available in the facility and in a folder kept in each resident's bedroom. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. An advocate from the health and disability office provides staff training and attends a residents' meeting annually which last occurred in November 2018. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br><br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents 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, activities, and entertainment. There were currently five residents who remain independent in accessing and attending their local community and daily activities.<br><br>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | 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. A copy of the policy and a complaint form is located in a folder in each resident's bedroom as observed on the days of audit.<br><br>The complaints register reviewed showed that the last recorded complaint was received in December 2017 and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. Members of the senior management team are responsible for complaints management and follow up with 'sign off' being undertaken by the CEO/owner. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery<br><br>Consumers are informed of their rights. | FA | 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, discussion with staff and the information provided throughout the facility. The Code is displayed in the main foyer area together with information on advocacy services, how to make a complaint and feedback forms. |

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| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.<br><br>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor and accessing the community. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.<br><br>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.<br><br>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. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>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 | Staff support residents in the service who identify as Māori 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 whānau. The clinical nurse manager interviewed reported that there are two residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. For residents that affiliate with their Maori culture, a specific current Māori assessment is completed, and all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into the long-term Maori care plan. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Whanau and the Maori residents were not available for interview, however staff interviewed were able to discuss how they acknowledged and respected the residents' individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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, food preferences and private time for daily prayer. The resident satisfaction survey confirmed that individual's needs were being met. |

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| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care and dialysis nurse specialists, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.<br><br>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.<br><br>Other examples of good practice observed during the audit included one to one interactions and conversations between staff, residents and family, and the knocking on doors before entering a resident's room. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed 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 also 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. Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English. One resident was identified with sensory impairments and all equipment and/or consumables were available, for example, signage on the door and an in-depth individualised and specific care plan to support both the resident and staff. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate | FA | 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. Set goals are signed off upon completion. A sample of monthly reports to the CEO/owner showed adequate information to monitor performance is reported including quality data analysis, incidents and accidents, complaints, emerging risks and issues. |

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| to the needs of consumers. | | The CEO/owner works at the facility at least three days per week and is aware of any issues that arise. She has owned and operated the facility for 23 years. The day to day management of the service is overseen by the facility manager who has been in the role for 11 years. The current clinical nurse manager, who commenced in this role on 26 November 2018, previously worked at the facility as a registered nurse. She oversees all aspects of clinical management. (The previous clinical nurse manager has stepped down to a registered nursing role whilst she undertakes post graduate study). The CEO/owner, facility manager and clinical nurse manager form the senior management team and they all hold relevant qualifications and experience for their roles. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Members of the senior management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through attendance at age care meetings and education sessions, on and off-site training and Counties Manukau District Health Board (CMDHB) forums. The CEO/owner is a recently elected member for the National DHB Age Related Care steering group.<br><br>The service holds contracts with CMDHB for under 65, respite, hospital, rest home, medical conditions. There were 23 residents receiving services under the Age Related Residential Care contract, one respite care resident (ACC), one resident is under the Long Term Chronic care contract. One resident is under an Individual Treatment Bed contract (Mental Health and Alcohol and Other Drugs) with the Northern Region DHB at the time of audit. There were 10 hospital level care and 16 rest home level care residents.<br><br>The service also holds a Residential Non Aged contract but no residents were receiving care under this contract at the time of audit. |
| Standard 1.2.2: Service Management<br><br>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 | When the CEO/owner is absent, the facility manager carries out all the required duties under delegated authority. When the facility manager is absent the CEO/owner undertakes this role. During absences of key clinical staff, the clinical management is overseen by a registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and | FA | 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 accidents and falls, and pressure injuries.<br><br>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related |

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| risk management system that reflects continuous quality improvement principles. | | information is reported and discussed at the senior management team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls as confirmed in documentation sighted. For example, follow-up occurred related to the medication audit resulting in all residents' photographs being updated. Also refer to comments in criteria 1.3.4.2.<br><br>Resident and family satisfaction surveys are completed annually. The most recent survey, December 2018, showed that all residents and family are either satisfied or very satisfied with the services they receive. Two minor issues raised related to food variety and entertainment have been fully addressed with the residents concerned. They have both been closed off. No negative comments were made by residents or families during interviews at the audit.<br><br>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 managed by an off-site company and individualised to the service. They are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.<br><br>The senior management team described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The team are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. The risk register is up to date and there is a nominated health and safety champion who undertakes all health and safety requirements to meet the Act. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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 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 both management and staff meetings.<br><br>Members of the management team described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, or any other service since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications (eg, public health). |
| Standard 1.2.7: Human Resource Management | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed |

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| Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | | confirmed the organisation's policies are being consistently implemented and records are maintained. The service has introduced an electronic tool to identify when staff competencies, annual appraisals and annual practising certificates are due and this is monitored by the facility manager.<br><br>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 showed documentation of completed orientation and a performance review after a three-month period and then annually. All staff appraisals sighted were up to date.<br><br>Continuing education is planned on a biannual annual basis, including mandatory training requirements. Many staff have over 20 years' service with the organisation. Care staff who have not completed or commenced a New Zealand Qualification Authority education programme are encouraged to do so. Education is conducted at least monthly with additional education completed as required. For example, peritoneal dialysis management, electronic medication competencies and palliative outcome initiatives (POI) presented by hospice. Staff are encouraged to identify any ongoing training and education they wish to attend related to their role during the annual appraisal.<br><br>There are four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual interRAI performance appraisals. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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 (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours 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 available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There are 19 clinical staff with current first aid certificates to ensure that at least one staff member on duty holds this certificate. There is 24//7 RN coverage.<br><br>Domestic staff (laundry and cleaning) work seven days a week 8 am to 3 pm. A cook works 8 am to 5.30 pm and a kitchen hand 4.30 pm to 8 pm seven days a week. An auxiliary staff member works 8.30 am to 3 pm and undertakes activities and assists with meals Monday to Friday. The facility manager works 7 am to 3.30 pm Monday to Friday. The clinical nurse manager works 8 am to 4.30 pm Monday to Friday and is on call as required. The CEO/owner works at the facility at least three days per week and is on call. |

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| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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.<br><br>Archived records are held securely on site and are readily retrievable using a cataloguing system.<br><br>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. 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 and the GP for residents accessing respite care.<br><br>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. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | 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 communication, planning and appropriate documentation between the GP, ambulance staff and acute setting, family and resident. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.<br><br>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 |

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| timely manner that complies with current legislative requirements and safe practice guidelines. | | responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.<br><br>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.<br><br>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.<br><br>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. The facility does not store flu vaccines on site.<br><br>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 is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.<br><br>There is one resident who was self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.<br><br>There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by two cooks and kitchen team assistants and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. The menu was reviewed by a qualified dietitian in 2017. Recommendations made at that time have been implemented.<br><br>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with a food safety plan. The facility has provided documented evidence that an external provider for verification of their food plan/service has been acquired and the facility is currently seeking registration with their local authority. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.<br><br>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. Special equipment, to meet resident's nutritional needs, is available. |

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| | | Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys 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. |
| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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 | 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. There is a clause in the access agreement related to when a resident's placement can be terminated. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | CI | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, and nutritional screening, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of four trained interRAI assessors on site which included the clinical nurse manager. The facility has implemented and supports a pressure injury prevention and management of chronic wound programme. The facility has access to, utilises and is supported by the wound nurse specialist which was evidenced in documentation and regular correspondence. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | 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.<br><br>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. All staff, having read any changes to care plans, are required to sign alongside the change in acknowledgement. Residents and families reported participation in the development and ongoing evaluation of care plans. |

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| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care 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 excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment, external specialist support and resources was available, suited to the levels of care provided and in accordance with the residents' needs. |
| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by an axillary staff member and activities co-ordinator. The residents are supported Monday to Friday for four hours a day.<br><br>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. The resident's activity needs are evaluated daily and as part of the formal six-monthly care plan review.<br><br>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events and van trips are offered. The axillary staff member visits each resident daily and for residents that are bed bound and/or choose not to come out of their bedrooms, one to one activities and daily conversation is provided. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.<br><br>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/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the |

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| Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | | 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 wound and dialysis nurse specialists, mental health services and the hospice. The resident and the family/whānau are kept informed of the referral process, as 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. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>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 | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals have completed appropriate education and training for safe chemical handling. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide the 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.<br><br>There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 30 November 2019) was publicly displayed.<br><br>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The service has replaced 30 beds with hospital level care hi-low beds. The testing and tagging of electrical equipment (06 April 2018) and calibration of bio medical equipment (11 April 2018) is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.<br><br>External areas are safely maintained and are appropriate to the resident groups and setting.<br><br>Residents and family confirmed they are happy with the environment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one double bedroom with a full ensuite and one wing of eight bedrooms have a shared toilet between two bedrooms. Appropriately secured and approved handrails are provided in the toilet/shower |

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| 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. | | areas, and other equipment/accessories are available to promote residents' independence |
| Standard 1.4.4: Personal Space/Bed Areas<br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There is one double bedroom with two beds and all other rooms are single accommodation. When the double bedroom is shared the service seeks approval to do so. Rooms are personalised with furnishings, photos and other personal items displayed.<br>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. There is a separate dining area and three lounge areas which can be used for activities. All areas enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. |
| Standard 1.4.6: Cleaning And Laundry Services<br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being | FA | Laundry is undertaken on site in a dedicated laundry area. Dedicated domestic staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.<br>Domestic staff have received appropriate training in safe chemical use, as confirmed in interview and in training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled |

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| provided. | | containers.<br><br>Cleaning and laundry processes are monitored through the internal audit programme and visual checks. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are 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 approved by the New Zealand Fire Service on the 15 December 1998 and there have been no changes to the facility footprint since this time. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 21 August 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.<br><br>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 35 residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.<br><br>Call bells alert staff to residents requiring assistance. The service has updated its call system (May 2018) to include ceiling mounted alerts for staff as well as an audible sound. The system shows if an exterior door is opened after hours. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.<br><br>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and checked by staff. Exterior doors are alarmed at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by electric wall heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management<br><br>There is a managed | FA | 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 the GP and pharmacist as required. The infection control programme and |

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| 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. | | manual are reviewed annually.<br>The clinical nurse manager/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and CEO/owner and tabled at the management and full staff monthly meeting.<br>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter 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. |
| Standard 3.2: Implementing the infection control programme<br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for two weeks at the time of audit. She is currently undertaking online training in infection prevention and control. 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.<br>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures<br>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 | 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 2017 and included appropriate referencing.<br>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. |

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| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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.<br><br>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.<br><br>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. Trends are identified from the past year and this is reported by the clinical nurse manager and reported to the facility manager, CEO/owner and all staff at staff meetings. In April of 2018, 26 residents and seven staff consented to and had the flu vaccine.<br><br>The facility has had a total of 16 infections between June 2018 up until and including November 2018. One resident has been identified with three of those 16 infections due to co-morbidities. The resident's file reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | 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 should they be implemented. Policy identifies that enablers are the least restrictive and used voluntarily at their request. The facility is restraint free. On the day of audit, no residents were using restraints or enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility, should it be required. Staff education on the use of restraint alternatives and restraint policy and procedures occurs as part of orientation and as an annual competency. The restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and non-restraint practice and her role and responsibilities.<br><br>The management team confirmed that restraint would only be used as a last resort when all alternatives have been explored. Staff confirmed their awareness of the non-restraint policy and actions that must be |

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| | | taken should restraint be considered. |

# Specific results for criterion where corrective actions are required

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

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

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

| No data to display |
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# Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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 |
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| Criterion 1.3.4.2<br>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 | CI | The total number of falls within the facility continues to be reviewed and improved upon with monthly reviews. One resident had a total of ten falls from August 2017 through to July 2018. A complete multi-disciplinary review for this resident was carried out which included a full nursing assessment and physiotherapy review and full medical and medication review, resulting in medication changes. The residents had a physiotherapy review, equipment to support the resident was implemented and there was an increase in visual and toileting checks for the resident with the long-term care plan reflecting all interventions. As a result, the resident has not fallen in the last six months. A facility wide project was implemented to introduce these interventions for all residents. Data showed that for the year of 2017 there was a total of 68 falls, in 2018 through to September 2018 there was a reduction in falls showing a total of 47 falls. Since August 2018 through to the day of the audit there has been one resident fall. | The facility’s falls reduction programme and procedure implementation is rated as continuous improvement by demonstrating an ongoing review process and continual improvement. There has been increased resident and family satisfaction with the interventions initiated and developed in response to residents’ falls, and in turn, a significant reduction in residents’ falls. |

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| planning. | | | |

End of the report.