Hospital & Rehab Aotearoa Limited - Mitchell Court

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Hospital & Rehab Aotearoa Limited
Premises audited:	Mitchell Court
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 August 2021 End date: 12 August 2021

Proposed changes to current services (if any): Sale and purchase of service.

Total beds occupied across all premises included in the audit on the first day of the audit: 27

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

A prospective provider, Hospital and Rehabilitation Aotearoa Limited trading as Makoha Tauranga, has a sale and purchase agreement with Mitchell Court (Tauranga) Limited. Settlement is scheduled to occur on 30 September 2021 with takeover subsequent to obtaining approval from the Ministry of Health (MOH).

Mitchell Court provides rest home level care and short term/respite stay under agreements with their district health board (DHB) for up to a maximum of 35 residents.

This provisional audit was undertaken to establish the prospective provider's preparedness to deliver residential aged care services and the current owner's level of conformity with the Health and Disability Services Standards and their agreements with the DHB.

The prospective provider has experience in delivering aged care services and operates Makoha Rest Home in Rotorua, which delivers rest home, hospital and residential physical disability care. Interview with one of the directors confirmed knowledge and understanding of the aged care sector and their preparedness to own and operate an additional facility.

This audit process included a pre audit review of policies and procedures, review of residents' and staff files, observations and interviews with staff, the current owner/director, the facility manager, clinical manager, residents, family members, and a general practitioner (GP). All the interviewees spoke positively about the care provided.

There have been no significant changes to the services provided or the facility since the previous certification audit in March 2018.

This provisional audit revealed three areas that did not comply with these standards. These include a need to ensure that sufficient cleaning services occurs daily, that all entries into resident records include the designation of the writer and that two leaking gutters are repaired.

Consumer rights

Information is made available to residents with regard to the Code of Health and Disability Services Consumer Rights (the Code), and the Nationwide Health and Disability Advocacy Service. Residents and family confirmed they are treated with dignity and respect and are satisfied that their rights are being met. The cultural and spiritual values and beliefs of residents are acknowledged and incorporated into their care. Informed consent is consistently practiced. Residents and family are satisfied with the frequency and method of communication. Residents are encouraged and supported to take part in community activities

A complaints management process is clearly described in policy. Residents and relatives are advised on entry to the home about the processes for raising concerns or complaints and are given written information about their right to complain and where to access independent support and advocacy if required. The service was managing complaints fairly and openly.

Organisational management

The prospective provider has an integration and transition plan which was discussed during interview. This confirmed that due diligence in considering all necessary matters related to acquiring the facility and its operations had occurred and that there were short, medium and longer term plans for a smooth transition. Their intention is to make no or minimal changes in the first 12 months

in regard to staffing, service scope or the physical layout of the building and then gradually phase in their established quality, risk and human resources systems and the ‘Makoha model of care’.

In the medium to long term the prospective provider intends changing the scope for service delivery to include residential hospital aged care and physical disability which will replicate what is provided in their other facility. This will involve making alterations to the building and increase the number of beds available.

The prospective purchaser demonstrated knowledge and understanding about all the requirements for delivering residential health care under New Zealand legislation, these standards and funding agreements. The prospective purchaser has current business, quality and risk management plans which include the scope, direction, goals, values and mission statement of the organisation.

Mitchell court have an established quality and risk management system which includes the collection and analysis of quality improvement data. Staff are involved in monitoring service delivery and feedback is sought from residents and families.

There is a system for reporting and documenting adverse events. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff adheres to good employment practices. A systematic approach to identify and deliver ongoing staff 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. Up to date, legible and relevant residents’ records are maintained in hard copy files.

Continuum of service delivery

Residents’ needs and goals are assessed at appropriate timeframes and care-plan interventions are implemented based on multidisciplinary team input, and current best practice guidelines. Resident care is provided by a team of care-staff who are suitably qualified, with oversight provided by registered nurses.

An activities programme is available six days per week and involves in-house and community activities. All residents have a personalised activities plan.

Medication prescribing and administration reflects legislative and recommended practice guidelines. Staff are skilled and competent to perform medicine management tasks. Resident's medications are reviewed three monthly by the general practitioner.

Meals are cooked on site and residents with specific dietary needs have these met. The menu is approved by a registered dietician. Residents reported satisfaction with the food service.

Safe and appropriate environment

Waste and hazardous substances are managed safely. Staff have access to protective equipment and clothing and were observed using this. Chemicals are safely stored.

The building is in an acceptable condition, has a current building warrant of fitness and meets the needs of residents. The prospective purchaser has obtained a building inspection and report. Electrical and medical equipment has been checked and tested as required. External areas are accessible and provide shade and seating for residents. All internal and external areas of the home are maintained as safe.

Laundry services are effective and managed by a designated laundry person five days a week. Care staff undertake laundry tasks on the weekend.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

Residents reported a timely staff response to call bells. Security is maintained. Communal and individual spaces are maintained at a comfortable temperature.

Restraint minimisation and safe practice

The service has a restraint and enabler policy; however, no restraints are used in this service. Staff are educated on the restraint and enabler policy and de-escalation techniques. There was one enabler in use during the audit which was being used according to the requirements.

Infection prevention and control

An infection prevention and control programme is in place in this service. Policies and procedures reflect best practice, are practical and implemented in this service. All staff receive annual training that reflects current trends and recommendations. Surveillance is undertaken monthly; data and analysis is carried out and reported monthly. The service has a Covid 19 response plan that reflects the Ministry of Health's guidelines and has sufficient personal protective equipment on site to utilise should it be required. The facility's layout allows the service to be segregated into three wings to reduce cross infection in the event of an outbreak of an infection.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	3	0	0	0
Criteria	0	90	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff are provided training on the Code of Health and Disability Services Consumer Rights (the Code), and during interview discussed the Code and how it is implemented in their daily roles. Resident's rights as consumers of a health service were observed as being compiled with during the audit. Residents and family members interviewed stated they were aware of their rights and confirmed that they were met.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The informed consent and advance directives policy is used to guide practice. Admission agreements sampled contained signed consent for photographs, collection of information, and sharing of health information. In addition, consents were sighted for influenza and Covid 19 vaccinations. All files sampled contained signed advance directives, countersigned by the GP. Staff interviewed discussed the process of informed consent, and how it was obtained. During the audit staff were observed gaining verbal consent for routine daily care. Residents stated they were supported to make informed choices, and their right to accept or decline interventions was respected. Family stated they were advised

		when care-plan interventions were being considered.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with information regarding the national advocacy and support service at the time of admission. The local representative attends a resident meeting annually, and also comes to the service on request. Residents and family members confirmed that they were aware of the nationwide advocacy service and had the information available to contact the service if desired. Staff are made aware of the advocacy service on orientation and confirmed that that have the knowledge to support a resident to access the service if required. This was further verified by a complaints record which showed that a resident had approached the local advocacy service for support.
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	Friends and family are encouraged to visit residents during sociable hours. During the audit visitors were seen coming and going, with one visitor having lunch in the facility with a relative. Activities include community outings, such as, shopping, café visits and picnics. Members of the community contribute to the activities programme, for example performing music. Residents interviewed said they had free access to visitors, and went on outings in the community, with the service, and with friends or/and family. Family interviewed stated they felt welcome when they visited.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints process and related information meets the requirements of Right 10 of the Code. Information about how to raise a complaint is on display in various locations throughout the home and is explained to residents and families on admission. Residents and families said they understood their right to complain and that they would not hesitate to do so when needed. The complaints register showed there had been seven complaints received since the previous audit, none of which involved the Health and Disability Commission. One complaint by a resident involved the local advocacy service and another the DHB. The investigations and actions

		taken regarding each complaint were documented with an outcome reached within a suitable timeframe. The facility manager is responsible for complaint management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The prospective provider has well established complaints management processes and said that after takeover, complaints will be incorporated into the Makoha systems for monitoring and reporting.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and information on the Nationwide Health and Disability Advocacy Service was displayed in the entry foyer of the facility. Residents and family confirmed they were provided information retaining to their rights and felt comfortable raising these with staff. The prospective provider has knowledge of, and understands their requirements, under consumer rights legislation.
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	There were policies that address all the components of this standard. Resident's care-plans document interventions that contribute to maximising the resident's independence, and address the cultural, social and spiritual values and beliefs of individual residents. Staff interviewed described the policies and how they implement them, and the care-plan interventions, in daily practice. Resident meeting minutes confirmed that strategies to encourage independence and self-determination are promoted. During the audit staff were observed to be communicating, with residents and family in a respectful manner. The residents and family confirmed that services are provided in a manner that respects their dignity, privacy, spirituality and choices.
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	FA	The service has implemented a Māori health plan, which provides guidance to staff when providing care to residents who identify as Māori. During the audit there were three residents who identified as Māori. One file was sampled, the care plan reflected the mana and cultural

acknowledges their individual and cultural, values and beliefs.		requirements of the resident. Whanau visit the resident as desired, and are involved in care-planning, and are updated of any changes in the resident's condition. Staff interviewed and education records sighted, confirmed that Tiriti o Waitangi education has been provided.
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	The service has a range of policies which provide guidance on recognising and respecting individuals, culture, values and beliefs. Care-plans sampled documented the resident's individual cultural needs, values and beliefs. Residents confirmed they were able to attend church (or other spiritual) services of their choice and that staff respected their beliefs and values and their cultural practices.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff education records confirmed that all staff have received information to ensure awareness of discrimination, exploitation and professional boundaries. Residents and family interviewed stated that they had not witnessed discrimination, coercion, harassment or exploitation, and this was verified by the GP. Staff employment contracts addressed code of conduct expectations, and staff interviewed discussed these.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies and procedures that reflect current legislation and best practice guidelines, these are implemented and understood by staff. Health professionals from other disciplines or/and professionals with expert knowledge are accessed to assess and recommend care for residents when standard interventions are not achieving goals. For example, wound care nurse, clinical nurse specialist, and the aged care mental health team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The nurse manager was aware of the process of open disclosure and the sample of adverse events showed that significant others are notified about incidents in a timely manner. Records of communication with family are maintained and verified that family are notified regarding change in health status, or routine health status reviews. Residents and family

		members interviewed, confirmed that they were advised of any incidents and any subsequent actions arising from the incident. Resident meeting minutes confirmed that meetings are well attended, and matters raised during the meeting are discussed, and outcomes are shared with all residents and families as required. The nurse or facility manager can access interpreter services if required through the district health board.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Mitchell Court is part of the Cavell Group whose members are owners/service providers of another five aged care facilities. The Cavell group has an overall business strategic plan that includes the mission, values statement and philosophy of care. Each service including Mitchell Court, has its own quality plan with goals which are reviewed annually. Mitchell Court has been owned and operated by the same private owner since 2011. Maximum occupancy is for 35 residents. The service also has agreements with the DHB to provide care for people diagnosed as requiring care for their long term support –chronic health conditions (LTS-CHC) and short term/respite care. On the days of audit there were 27 residents receiving rest home level care services under the age-related care contract (ARCC) and eight boarders who were private payers. The only services provided to independent boarders are meals and laundry. There were no respite care residents or younger persons. Six of the 27 residents were being cared for under LTS-CHC. The average age of residents was 71. All residents had signed admission agreements. The current facility manager (FM) is a registered nurse who has been in the post for nearly five years. This person had previous experience in New Zealand hospital care. Their authority, accountability and responsibility for the provision of services is described in the position description attached to their employment agreement. The nurse manager (NM) is a registered nurse who was maintaining competencies to undertake interRAI assessments. Both the FM and the

		NM had attended at least eight hours of professional development within the last year in subjects related to aged care service delivery, management and leadership. Hospital and Rehabilitation Aotearoa Limited, trading as Makoha, Tauranga - the prospective provider, has proven experience in owning and operating an aged care/residential physical disability service at Makoha Home in Rotorua which achieved a three-year certification period with these standards. Interviews with one of the directors confirmed their knowledge and understanding of New Zealand legislation, and the contractual and care sector responsibilities/requirements. Both of the directors are registered medical practitioners. The director described processes for a smooth change of ownership to the Makoha methods of governance, care and management processes. This included timeframes and descriptions of the due diligence completed to date. There is no intention to make any significant changes to staffing, the services delivered or the building in the first 12 months. There will be a gradual introduction and incorporation of the 'Makoha model of care', and their systems for quality, risk, and human resources (HR) in the short to medium term. The funder Bay of Plenty DHB has been notified. There are medium to long term plans to change the service scope to hospital aged care and residential physical disability after making changes to the building. The sale and purchase agreement states settlement is for 30 September 2021 with handover subsequent to approval being received from MoH.
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	The facility manager and nurse manager cover for each other's leave and share the on-call requirement. The prospective provider was preparing to offer Mitchell Court staff an employment agreement under Hospital and Rehabilitation Aotearoa Limited-trading a Makoha Tauranga, according to their existing rosters. There are short term plans to have the Makoha Rotorua, nurse manager and other key staff regularly onsite at Tauranga to support the transition stages. This will also enable regular liaison with key stakeholders such as the local general practitioners, DHB, other service providers, residents

		and their families.
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 quality improvement principles.	FA	Currently the quality and risk management plan is aligned to the Cavell group's annual strategic/business plan which describes the systems for service monitoring, review and quality improvement. Service quality goals are documented in an annual plan which is monitored for progress by the current director/owner. Mitchell Court access the Cavell Group policies and procedures through the website and retain paper-based copies on site for staff to access. Polices are reviewed by the group at least two yearly to ensure they align with current good practice and meet legislative requirements. A pre audit review of policies and procedures showed these are individualised and updated as required by the Cavell group Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data is collected, analysed and compared monthly, six monthly and annually for a range of adverse event data (for example skin tears, bruising, falls, pressure injuries). Corrective actions are documented, implemented where improvements are identified and are regularly evaluated. Information about current infections, accidents and incidents, health and safety, concerns/complaints, internal audit outcomes and quality goals is shared with staff at their monthly meetings. Falls management strategies include sensor mats, and the development of specific falls management plan to meet the needs of each resident who is at risk of falling. Individual graphs for fallers identify time and location of falls to assist staff in the management and prevention of falls. This was confirmed in meeting minutes, displayed on noticeboards and during staff interviews. The quality data is benchmarked within the Cavell Group of facilities. Review of the documented outcomes from internal audits and incidents reported since the previous recertification audit in March 2018 confirmed the quality and risk system as effective and compliant with this standard. Minutes of residents' meetings confirmed that residents are consulted about service delivery and are kept informed. The service formally surveys resident satisfaction with food and activities at least once a year.

		Results of the 2021 survey revealed moderate to good satisfaction from the six respondents. Only thirteen surveys were distributed. There was some evidence that points raised from the feedback were acted on. The majority of resident feedback occurred at resident meetings and those residents interviewed said they were kept informed and consulted about services in ways that they understood. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk. The hazard register contained all actual and potential risks including the gutter and was being maintained by the nominated health and safety representatives. Staff receive health and safety training during their induction to the service and completed annually during their compulsory training day. All staff are involved in health and safety, which is a topic in the monthly quality/staff meetings. The health and safety staff representatives interviewed understood their roles, the legislation and carry out regular environmental safety inspections. The prospective purchaser plans to gradually introduce their quality and risk system and sector standardised policies. They demonstrated understanding about all risks related to operating a health and disability service and the requirements of the Health and Safety at Work Act 2015 including notifying staff when changes in practice or policies have occurred.
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	The service has known processes for reporting, recording, investigating and reviewing adverse events. The prospective purchaser demonstrated understanding of the requirements for adverse event reporting including making notifications under section 31. A sample of incident/accident records and monthly summary sheets for 2020-2021 showed there was a coordinated approach to the management and review of documented adverse events. Interviews with staff, and the NM confirmed that all incidents were reported, recorded and reviewed. Each event was investigated for cause and corrective/remedial actions implemented where necessary. The event forms reliably recorded who had been notified. Incidents and accidents are collated into graphs to compare the data

		month by month. This data was being shared with staff at their meetings and the graphs are displayed. Any unwanted trends result in mitigating strategies being implemented in a timely manner. There had been two section 31 notifications to the Ministry of Health since the previous audit. One was related to the availability of registered nurses and the other was related to a resident's deterioration in condition in August 2020.
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	The prospective provider interviewed, demonstrated knowledge and understanding about NZ employment legislation. They stated there would be no change to the current configuration of staff at Mitchell Court in the short term. Their human resources management systems will be gradually introduced in the first 12 months. The prospective provider stated that the performance development and competency testing systems in use at Makoha-Rotorua will extend to Makoha-Tauranga after takeover. Staff at Mitchell Court had been recruited and managed in accordance with good employer practices. The skills and knowledge required for each role was documented in position descriptions and employment agreements. All staff interviewed confirmed they understood their roles, delegated authority and responsibilities. Each of the staff records sampled contained curriculum vitaes (CVs), educational achievements, evidence of referee and police checks, and current practising certificate for the registered nurses. New staff are oriented to organisational systems, quality and risk, the Code of Health and Disability Services Consumers' Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint minimisation, infection prevention and control and emergency situations. The records sampled also contained copies of annual performance appraisals. Staff maintain knowledge and skills in emergency management, and competencies in medicine administration. The 2021-2022 staff training calendar and attendance sheets showed that in-service education is provided monthly on a range of subject areas including infection control, residents' rights, manual handling and health and safety. Staff were being supported to engage in ongoing training and education related to care of

		older people or the tasks they are employed for. All care staff have completed level four of the national certificate in health and wellness. Of the two RNs employed (FM and NM) the NM is maintaining competencies to undertake interRAI assessments. Allied health staff for example, cooks, the cleaner and laundry staff attend in service education and had completed training relevant to their role, such as safe handling of chemicals and food safety.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Discussion with the prospective provider in regard to their transition plan revealed no changes with the configuration and numbers of staff currently employed. They intend to maintain the same rosters unless there is a need to change for resident safety. Recruitment is underway for more care staff and RNs. The staffing policy adequately described the process for determining stall levels/skill mix and a staff to resident ratio protocol. The staff rosters included appropriate levels of staff and skill mix. Review of previous months and future planned rosters confirmed an appropriate number of staff on site for the needs of the current resident population. Two care staff were rostered on duty each morning, two in the evenings and one care staff member at night. The activities coordinator is employed for 26 hours a week (Monday to Thursday) from 10am to either 4pm or 6pm and another person provides activities on Fridays and Saturdays from 11am to 3pm. The head chef works Monday to Friday with other kitchen staff designated suitable hours for food preparation and service. The designated laundry person is on site for a suitable number of hours Monday to Friday and care staff attend to the laundry during the weekends. The sole designated cleaner is on site for 12 hours a week, four hours a day on Monday, Wednesday and Friday. Residents and staff interviewed expressed dissatisfaction with the extent of cleaning. An improvement is required in criteria 1.4.6.2. The FM who is a registered nurse plus the nurse manager are on site during business hours Monday to Friday. These two RNs share responsibility for after hours on call, seven days a week. Staff said that

		the NM always responds to their calls, and that they seldom need to make a call. The residents interviewed said they were satisfied with the availability of staff. Family members said they had no concerns about staffing. All the staff interviewed expressed job satisfaction and there has been a low staff turnover.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	There is a policy that addresses the requirements of this standard. An electronic medication management system is used that is password protected, however all other resident information management is paper based. Records are kept in a filing cabinet in a locked office. Records not currently in use are stored in boxes in a locked cupboard. Each box contains files specific to an individual resident. No resident information is able to be sighted by other residents or members of the public. Resident paper-based files sampled confirmed that the residents name and national health index number (NHI) is recorded on each page. An entry is recorded in the resident's progress notes each duty, and each entry records a date, time, and signature. The integrated record includes all clinical information relating to the resident, including information provided by other health care providers. Not all entries record the designation of the staff member documenting in the clinical record. See improvement in criterion 1.2.9.9.
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 services has been identified.	FA	Entry to the home is following a needs assessment and service co-ordination (NASC) referral. Potential residents are invited to visit the service prior to entry. If staff are unsure about the potential resident's suitability a further assessment is undertaken, for example the resident may be invited to stay for a short period as a respite client, prior to permanent placement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition,	FA	Transfer, transition or discharge is planned, co-ordinated and facilitated by the nurse manager and/or the facility manager. Transfer from the service occurs when the resident requires care that is beyond the scope

exit, discharge, or transfer from services.		of the service. Every resident's file sampled contained an interRAI transfer document prepared by the nurse manager that accompanies the resident to the receiving facility. If care-staff are concerned about a resident's health status out of business hours, the nurse manager or facility manager is notified, and the care-staff arrange a transfer to hospital via ambulance, with the interRAI transfer document, and any other relevant documents. The family is notified of the transfer, confirmed in files sighted, and during family interviews. Residents are discharged from the service when their needs are unable to be met by the service. An updated interRAI assessment is undertaken, and the nurse manager notifies the NASC service of the need for discharge. The discharge process is discussed with the resident and family in a timely manner by the nurse manager and/or the facility manager. The nurse manager supports the family to access suitable alternative accommodation.
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.	FA	There is a current medicine management policy which meets requirements. The service uses an electronic medication management system and pharmacy packaged medication packs. All medication files sampled met legislative requirements. A medication round was observed and practice reflected best practice guidelines. Care-staff administer medications. Education records and staff interviews verified that staff are competent to perform this function. Specimen signatures are kept ensuring traceability of all administration. Medications are stored in a locked room, accessible to staff only. The room was free from direct heat, moisture and light. The medication fridge was temperature monitored and records confirmed the range was within recommended guidelines. The service does not use standing orders. Controlled medications are stored and recorded as per legislative requirements, including weekly checks and six monthly stocktakes. One resident self-administers their own medication, and six-monthly competence verification was documented by the GP. The resident was interviewed and confirmed that self-administration occurs as per policy. A

		safe was sighted in the resident's bedroom to store the medication. The medication room was not temperature monitored; however, this was commenced during the audit. A medication fridge is used to store medications that require refrigeration, temperature records were sighted and confirmed to be within the recommended range. The fridge was observed to have excessive ice in the ice box, and there were no cleaning records available for the fridge on the day of the audit. Not all insulin stored in the fridge was in use, two boxes had expired, and one box was labelled for a resident who was no longer in the service. These were disposed of during the audit.
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	The food service caters for the individual requirements of all the residents, including those that have for example allergies, diabetes, gluten intolerance, or require soft foods, and/or thickened fluids. The chef has appropriate qualifications and experience in meal service. There is a summer and winter menu which has been approved by a registered dietician. The kitchen was clean and organised, with adequate supplies of fresh and canned food. All stored food had the best before date identified, and prepared food stored in the fridge was covered and dated. Cleaning records of appliances are kept. The food control plan is valid until October 2021. Residents interviewed stated satisfaction with the food service.
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	Residents are declined entry if there are no beds available of if the needs of the resident are unable to be met by the service. Potential resident's service needs are discussed with family members and other relevant health professionals to gather suitable information to inform decision making. The resident, family and referrer are informed if the referral is declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are	FA	All files sampled contained completed assessments that were completed in a timely manner. These included the initial assessment and care-plan that was completed on admission and the initial interRAI assessment and

gathered and recorded in a timely manner.		resultant long-term care-plan that was completed within three weeks of admission. Assessments included, for example, a falls risk, pressure area risk, skin assessment and continence assessment. Resident focused goals reflected the documented assessments. Ongoing interRAI assessments are completed six monthly. All files sighted contained documentation of the residents monthly vital signs and weight. Residents and family members interviewed confirmed that had been involved in the assessment process
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	All dimensions of the resident's health were included in the long-term care-plans sighted including for example, the cultural, spiritual, emotional and physical needs of the resident. The care-plans recorded resident centred goals, and interventions appropriate to achieve the documented goals. The resident, and/or the resident's family had signed the care-plan. Short term care-plans are developed to guide continuity of care for acute conditions for example, an infection or a skin injury. There were no residents with a short-term care plan in place during the audit, however previous completed short-term care plans were sighted. These identified goals, and interventions that were appropriate to meet the resident's needs, an evaluation had occurred and the plan had been signed off as complete. Both short and long-term care plans integrated care recommendations from the multidisciplinary team, including for example the GP, physiotherapist, clinical nurse specialist to ensure current best practice is implemented.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care-plans sampled contained interventions that reflected the residents needs and goals. There was evidence that the GP had reviewed the resident three monthly, or more frequently if required. Interviews with residents and family members confirmed that interventions were being delivered and met expectations. The service had adequate continence supplies on hand to meet the

		needs of the residents. Sufficient and appropriate dressing supplies were sighted to meet the requirements/needs of the service.
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.	FA	The activities programme operates six days per week, for various hours and is run by two co-ordinators. One co-ordinator runs the programme four days per week, the other two days per week. The co-ordinator who operates the programme four days per week was interviewed. A monthly programme is developed that includes a wide range of activities to meet the needs of all residents, and an attendance record is maintained. The co-ordinators meet each resident for a one-to-one chat daily, and where it is determined that a resident has needs that require increased one to one time, this is planned and provided. A personalised activities plan was sighted in every resident's file sampled, that confirmed the activities co-ordinator meets each resident at admission and develops a plan. All activities care plans were reviewed six monthly in collaboration with the resident, the nurse manager and family where appropriate. These were then integrated into the long-term care-plan. Residents and family interviewed confirmed they were satisfied with the activities programme. During the audit the co-ordinator was observed to be interacting with the residents one to one and leading a group exercise class in the morning and bingo in the afternoon.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All long-term care-plans sampled were evaluated six monthly, following an interRAI assessment. There was documentation to confirm that the resident and the family had been involved in the evaluation and subsequent modification to the care-plan. Short-term care plans were evaluated weekly or as appropriate to monitor response to the interventions and signed off as completed when the ailment had resolved. Where progress is different from expected the service refers to resident to an appropriate health professional for assessment and care

		recommendations. This was confirmed during interview with the GP and during interview with the resident.
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 to meet consumer choice/needs.	FA	The clinical records sampled contained evidence that other health and disability services are involved in the residents care as required. These included for example a physiotherapist, podiatrist and aged care nurse specialist. Residents are referred to the public hospital for medical care in acute circumstances. Residents and family members interviewed confirmed that the service accesses other health and disability services as required.
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	Policies and procedures related to waste are documented and comply with legislation and local authority by-laws. Staff interviews, observations and visual inspection of all areas revealed that there are no hazardous substances stored on site. Household and biological waste is disposed of appropriately. A sharps collection box is stored securely. All body waste is handled using standard precautions. Incontinence products are placed in an outside receptacle for weekly collection and disposal. There is minimal food waste and the management of this and/or other organic waste complies with environmental guidelines. A designated bin for infected waste is stored outside and staff understood when to use it. There were sufficient supplies of personal protective equipment (PPE) on site. Staff were observed to be using hair nets, aprons and gloves when engaging in food handling, personal cares, cleaning or laundry tasks. The facility has one small sluice room which doesn't contain a sanitizer. This was assessed as appropriate for the scope of the service (rest home only). There were no bed pans in use and the same urinal bottle was designated to the sole resident who used it at night. Suitable cleaning and sanitising processes were occurring.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible	PA Low	There were established systems in place to ensure the physical environment and facilities are safe and fit for purpose. The facility has a

physical environment and facilities that are fit for their purpose.		current building warrant of fitness that expires on 14 October 2021. Reactive and preventative maintenance is completed by a maintenance person and external contractors are available as needed. This was confirmed by the maintenance records reviewed and interview with the employed maintenance person. Electrical equipment had been tested and tagged and fire suppression systems are checked monthly by an external fire service. Medical equipment such as weigh scales and blood pressure monitors were being tested and calibrated at least annually. There were no hoists on site. Internal areas, furniture and fittings in the home were being maintained in good repair. Paintwork on the exterior window ledges was degraded in some areas and a number of bedroom curtains require replacement due to tears and damage. Review of the hot water temperature recordings showed these were below 45 degrees Celsius from taps that residents could access and over 60 degrees Celsius in the laundry and kitchen as required for sanitation. The external areas contain appropriate seating and shade. Gardens, lawns and other vegetation is maintained by the maintenance person. There were a number of not in use, older plastic chairs and rusted tables stored outside the home in the staff only area. There were at least two other internal rooms used for storage of unused equipment such as shower stools, walkers, beds and furniture, civil defence boxes and surplus bedding. Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs. Care staff and the NM confirmed there was sufficient and appropriate equipment available to safely deliver resident care as described in care plans. The prospective purchaser has inspected the environment and has no plans to make changes to the buildings or the physical environment in the short term/first 12 months. An improvement is required regarding outdoor maintenance.

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	Not all of the bedrooms have hand basins. Twelve bedrooms have their own ensuite bathrooms, six had toilets only. Rimu wing had 10 bedrooms with two communal bathrooms within easy walking distance to resident's rooms. These communal toilets were also being used by other residents when they were in the main lounge and dining areas. There are four self-contained units with kitchenettes and bathrooms on site. Three of these are occupied by boarders and one is occupied by a rest home level care resident. One of the units is owned by its occupant and arrangements have been made to buy this. One unit is occupied by two female boarders. Residents do not cook in these units as all meals are provided but most had microwaves for heating food. There is another rest home wing of larger self-contained type rooms that contain separate bathrooms. One is occupied by a couple. Occupants of these rooms pay additional charges. The residents interviewed were happy with the provision of toilets, shower and bathing facilities. Interview with the prospective provider revealed there are plans to demolish the four units and replace these with bedrooms suitable for hospital/and /or physical disability residents in the medium to long term.
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	There were three wings in the home. Rimu wing had 10 bedrooms. At least four of these bedrooms were less than 900square metres which would not accommodate lifting equipment or large wheelchair. These rooms contained a single bed, drawers and a chair. One bedroom is occupied by a resident who has a habit of hoarding. There is an agreement that staff can access this room weekly for cleaning and clearing. There is another rest home wing of larger self-contained type rooms that contain separate bathrooms. One is occupied by a couple. Occupants of these rooms pay additional charges. Residents can bring in their own furniture and decorate their personal space according to their preferences. Those interviewed were satisfied with their rooms. Interview with the prospective provider revealed there are plans to demolish the four units and replace these with bedrooms suitable for

		hospital/and /or physical disability residents in the medium to long term.
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 communal areas include the main lounge and dining area and a second lounge and dining area. There is a 'media room' with television, internet and computer available for all residents to use. This is very popular with residents and can be used for visiting family/friends or residents can take visitors to their bedrooms for privacy. These areas were easily and safely accessible 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.	PA Low	The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Where improvements can be made these are implemented. Boarders are expected to clean their own rooms. A designated laundry person is on site for sufficient hours Monday to Friday. Equipment in the laundry includes two commercial grade washing machines, one is relatively new and two clothes driers. One is a domestic type drier and the other is a large industrial drier. The laundry, equipment and supplies provided are suitable for the level of services provided. There were material safety datasheets for each chemical product located where the chemicals were stored. The chemicals are stored appropriately in locked cabinets at all times. The cleaner's trolley is stored in the locked staff toilet room when not in use. The chemical mixes are prepared from a wall-mounted system, which works effectively. An improvement is required regarding the frequency of cleaning.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The facility evacuation plan was approved by the Fire and Emergency New Zealand in 2015 and confirmed again by letter in 2018. The most recent trial evacuation occurred in March 2021 and records showed these are occurring regularly every six months. The results of trial evacuations are recorded to show the time taken to clear the building and any issues that arose. A hard-wired fire suppression system including sprinklers and smoke detectors are installed, and emergency exit signs

		are clearly displayed. All required firefighting equipment was sighted, and this is checked monthly by an external contractor. Staff confirmed their awareness of emergency procedures. They complete competency questionnaires prior to their annual performance appraisal. The orientation programme includes fire and security training. There is always at least one staff member on duty with a current first aid certificate. A civil defence plan is in place. The civil defence kit contains essential emergency supplies and equipment such as portable torches and batteries and is checked regularly. There is sufficient water and food available for the needs of 35 residents for three to five days. This adheres to the Ministry of Civil Defence and Emergency Management recommendations for emergency water storage in the Thames-Coromandel region. A gas hot plate and gas cylinder is stored ready for cooking in the event of power outage. Emergency lighting is provided by battery which will run for three hours. This system and egress is checked by the external fire service contractors. The call bell system is functional, and staff were observed to respond to the bell immediately. Residents and family members said staff were always attentive and responsive. The external doors are secured at dusk and there is a bell at the front door for visitors to ring after hours. Access to the facility via the main entry door is through a gate with a keypad lock, but the combination for opening this is on display. Residents were observed to come and go using this system. Sensor lights are situated around the exterior of the building and there are closed circuit cameras (CCTV) installed in common areas, for review of incidents. Residents, staff and visitors are alerted to these. Residents sign their consent for the use of these in the admission agreement. The prospective provider has no plans to change any of the emergency or security systems in the short term.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe	FA	All areas of the home have sufficient natural light. Each bedroom has at least one normal sized opening window and some have large sliding

ventilation, and an environment that is maintained at a safe and comfortable temperature.		doors to the exterior. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Heating is provided by electricity on wall mounted panel heaters and/or heat pumps in the dining and lounge areas. There are surplus quilts and blankets for additional warmth in the event of an electrical power outage. Family and residents interviewed confirmed the facility is maintained at a comfortable temperature all year round. There have been no complaints or issues raised about temperatures in the residents' meetings nor in the building maintenance logs.
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 service has an environment that minimises the risk of infection to residents, staff and visitors, by implementation of the infection prevention and control programme. The nurse manager oversees the implementation of the programme, with monthly reports provided to the facility manager and the governing body. The infection prevention and control plan is current, reviewed annually, and appropriate for the size and scope of the service. There have been no infection outbreaks since the previous audit. Visitors are requested to sign in on entry to the service and scan the Covid-19 QR codes. Staff who are unwell, take leave, and visitors who are unwell are encouraged to stay at home.
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 nurse manager oversees the implementation of the programme. In each wing of the facility an infection control box was sighted containing a sufficient supply of personal protective equipment (PPE) resources. The nurse manager stated specific information and guidance can be sought from the GP, medical officer of health, laboratory and the district health board infection prevention and control clinical nurse's specialists as/when required. Staff are made aware of residents who have an infection through shift handover reports, and short-term care-plans that ensure consistent management. Hand sanitisers are available throughout the facility, and observed to be in regular use by staff, residents and visitors at home.

		Staff interviewed were aware of the infection prevention and control programme and described the principles of infection prevention and control.
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	There is a suite of infection prevention and control policies and procedures that reflect current recommended best practice. The policies and procedures are readily available to staff on-line and in hard copy. There is a procedure that guides the correct use of a use of personal protective equipment (PPE). The policies and procedures are relevant to the service type and size. Policies and procedures have been reviewed and modified as required to reflect the Ministry of Health (MOH) advice and guidelines with regard to the Covid 19 pandemic. The facility has three wings, which can be isolated if required, and each wing has its own supply of personal protective equipment (PPE). Staff and resident education leading up to and throughout the pandemic, has focused on hand-hygiene, and cough and sneeze technique.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff records confirmed that all staff complete annual infection prevention and control training relevant to their roles, and this was confirmed during staff interviews. Staff education is delivered at regular in-service sessions and by on-line resources. The NM who is the infection coordinator, attends regular external education and professional development on infection control matters, confirmed by interview and personnel records. Residents are provided education with regard to infection prevention and control, as opportunities present. In particular, residents are reminded of hand hygiene techniques, the use of tissues, and coughing and sneezing etiquette. During the audit staff and residents demonstrated knowledge of the principles of infection prevention and control, and confirmed they received on-going education in response to the Covid 19 pandemic.

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	The infection prevention and control programme determines surveillance type and includes for example, monitoring of infection types, numbers and antibiotic use. Infection control data was sighted, which included monthly reports that analysed and identified trends. Surveillance data is benchmarked against other similarly operated services. The surveillance programme is appropriate to the size and complexity of the service. The GP confirmed that they are notified in a timely manner of any resident with a potential infection.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint policy that guides practice and defines restraints and enablers. Staff interviews and education records confirmed that staff have received education on the policy, and the use of restraints and enablers. Staff discussed de-escalation techniques and management of unexpected behaviours. The service does not use restraints. One enabler was in use during the audit, this was documented in the care-plan, and implemented at the request of the resident. The prospective provider was interviewed and is aware of the restraint standards and confirms the service will be operated to comply with the standards.

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 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Documentation in clinical records sampled recorded the date, time and signature of the person making the entry, however the designation of the staff member was not always identifiable.	The designation of the staff member documenting in the clinical record is not always identifiable	Ensure all staff members include their designation when making an entry in the clinical record. 90 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	The physical environment is being routinely maintained. All equipment, furniture and chattels are in good repair. Regular monthly checks on all internal and external areas are carried out by the maintenance person who reports any concerns about the environment to the FM and director/owner. There were two loose and leaking gutters outside the wing which accommodates the larger bedrooms with separate bathrooms. These pose a minor risk if they were to separate completely from the	There were two loose and leaking gutters which pose a minor risk of falling from the roof line.	Ensure all exterior areas are kept safe. 90 days

		roof line. This had already been notified to the prospective purchaser via a building inspection. The prospective purchaser has conducted a full building inspection.		
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Low	Residents and staff expressed dissatisfaction with the frequency of cleaning in the home. Specifically for the communal bathrooms in Rimu wing. One resident complained about regular malodour from the toilets and it was observed that some residents were leaving their incontinent briefs on the bathroom/toilet floor in the mornings. Staff were concerned about the limited number of hours that a cleaner is on site. The sole designated cleaner is employed for 12 hours a week, four hours a day on Monday, Wednesdays and Fridays. The maintenance person carries out essential cleaning on Tuesdays and Thursdays but there were no designated cleaning hours on the weekend. Care staff and other staff said they help out where they can. There were not enough hours for one person to complete all daily cleaning required, considering the layout and size of the building and the number of bathrooms/toilets and bedrooms. The eight boarders are expected to carry out cleaning of their rooms. As mentioned in 1.4.4. one resident is subject to hoarding and their bedroom requires extensive cleaning each week. The director said that recruitment for cleaning staff is ongoing. There were previously two cleaners employed who frequently failed to turn up for work. Internal audits of the environment and cleaning services did not reveal any areas for improvement. Kitchen staff are responsible for cleaning in the kitchen and the laundry person keeps the laundry area clean. All other areas in the home were inspected and found to be	There were insufficient hours or staff allocated for cleaning duties.	Allocate sufficient hours and /or staff to conduct regular cleaning services. 90 days

		sufficiently clean.		

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.

No data to display

End of the report.