

# Westmar 2021 Limited - Westmar 2021

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	Westmar 2021 Limited	
<b>Premises audited:</b>	Westmar 2021	
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care	
<b>Dates of audit:</b>	Start date: 14 February 2022	End date: 15 February 2022
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	23	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	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
Yellow	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
Red	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

Westmar 2021 provides residential services for up to 28 residents requiring rest home and dementia level of care. On the day of the audit there were 23 residents. The service is managed by a manager who has co-owned the service since May 2021.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, the General Practitioner (GP), staff and management.

Residents, the GP, and family members interviewed were positive about the care delivery.

A partial provisional audit completed November 2021 verified the reconfiguration of beds across the rest home and dementia unit. This configuration has not been implemented and shortfalls are still in the process of being completed.

This audit has identified required improvements around staff signing the code of conduct, aspects of the quality management system, attendance at education, care plan interventions, medication charts, hot water testing, the maintenance schedule, and the proposed new access to the dementia unit.

## Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Policies and procedures that adhere with the requirements under the Health and Disability Services Consumers' Rights (the Code). The information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit in line with the facility's Covid 19 response framework.

There is an established system for the management of complaints.

## Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There are policies and procedures to provide appropriate support and care to residents with rest home level and dementia care needs. Services are planned, coordinated, and are appropriate to the needs of the residents. The owner/ manager is responsible for day-to-day operations. There is a business plan with identified values, scope and strategic direction including quality objectives. The business plan and quality plan have goals documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. An orientation programme specific to the role is in place for new staff. Ongoing education and training for staff includes in-service and online education and training.

Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around clients' needs. The integrated electronic residents' files are appropriate to the service type.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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An admission package is provided to family and residents prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses are responsible for all aspects of care planning, assessment, and evaluation of care with the resident and/or family input. Resident files included medical notes by the general practitioner and visiting allied health professionals.

The activity programme is developed to promote independence and meet the needs and preferences of individual residents. There are a variety of activities that are meaningful to residents including maintaining community links.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts were reviewed at least three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. There are snacks available at all times. There is dietitian review of the menu. Staff have attended food safety and hygiene training. Residents commented positively on the meals provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building has a current building warrant of fitness certificate, and all external areas were accessible and of an appropriate standard. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment has been serviced and calibrated.

The dementia unit is secure. Resident's rooms and communal bathrooms are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Housekeeping/laundry staff maintain a clean and tidy environment. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management

plan in place and adequate civil defence supplies in the event of an emergency. A staff member trained in CPR and first aid is always on duty.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. At the time of the audit there were no residents using restraint or enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme include policies, standards, and procedures to guide staff. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator has attended external training.

Surveillance data is collected, collated, and used to determine infection control activities, education, and resources within the facility. The infection control programme included audits of the facility, hand hygiene and surveillance of infection control events.

A pandemic plan was actioned, and Covid-19 policies and procedures have been developed and implemented. Westmar 2021 continues to implement current Covid-19 regulations.

## 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	38	0	6	1	0	0
Criteria	0	84	0	8	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with ten staff (four caregivers, two registered nurses (RNs), one diversional therapist (DT), one chef, one maintenance person and one housekeeper) confirmed their familiarity with the Code and its application to their job role and responsibilities. Interviews with seven residents (rest home level) and five relatives (four rest home and one from dementia care) confirmed that the services being provided are in line with the Code. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advance directive instructions. Staff are aware of advance directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents identified that the service actively involves them in decision making. Dementia files reviewed included activated enduring power of attorneys (EPOAs).</p>

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services and staff receive regular training on advocacy. Information about accessing advocacy services information is available in the information presented to residents and families at the time of entry to the service. Advocacy contact details are included on complaint forms and in complaint resolution letters. Advocate support is available if requested.</p> <p>Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. Residents and family members interviewed confirmed that the service made an effort to maintain contact with relative/family members when visiting could not occur during certain times of the Covid-19 response framework. Community links were evident within the examples provided. Residents are assisted to maximise their potential for self-help and to maintain links with whānau and the community by supporting them to go out into the community. The younger person with disability chooses activities they wish to participate in (if able). The activities programme includes entertainers and volunteers (when permitted).</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to the national advocacy services. Information about complaints is provided on admission. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Seven complaints were recorded since March 2021 to December 2021, there were no complaints received year to date for 2022. All complaints reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. All corrective actions are fed back to complainants in a timely manner, however, complaints and identified corrective actions are not always discussed at the combined staff/quality meeting (link1.2.3.6).</p> <p>One complaint was forwarded by the Health and Disability Advocacy Service to the Health and Disability Commissioner (HDC) in 2021 following a meeting with a group of residents. A follow up letter received from HDC on 17 January 2022 requesting clinical documentation, which was forwarded by the provider on 11 February 2022. The complaint remains open. Two complainants involved in the HDC complaint requested to be interviewed and confirm their complaint is unresolved.</p> <p>There is a letter on file from the coronial services dated 8 October 2021 to inform there will be no inquiry into a</p>

		<p>sudden death in 2018.</p> <p>Discussions with residents and families confirmed they understand the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss.</p> <p>On entry to the service, the RNs discuss the information pack with the resident and the family/whānau. The resident pack includes a summary of information relating to the Code and a pamphlet on the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Policies align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their privacy needs were met and that they were treated with dignity and respect. The owner/manager is the privacy officer.</p> <p>Staff receive regular training around recognising abuse and neglect (March 2021 and December 2021).</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Māori links are established through the DHB. Staff had training around cultural awareness at orientation and completed an online training module in April 2021.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	FA	<p>There is a policy that describes spiritual care. Monthly church services are conducted in the facility. Residents interviewed confirmed that their spiritual needs were being met. The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>satisfied that their cultural and individual values were being met.</p> <p>Information gathered during the initial assessment include each resident's cultural beliefs and values, are used to help to develop a plan of care. The resident satisfaction survey of 2021 confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	PA Low	<p>The facility has a staff code of conduct that staff sign as part of the employment process. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. 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. Residents interviewed reported that the caregivers respected them. Job descriptions include responsibilities of the position, however, the "code of conduct and house rules" document had not always been implemented and signed as required by the employment policy for new employees.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home level care and dementia level of care. The service has implemented an electronic resident management system for the last three months, supplementary documentation is readily available to access.</p> <p>The service has purchased a suite of evidenced based policies along with the electronic resident management system. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Combined quality/staff meetings are conducted monthly.</p> <p>A comprehensive handover process promotes continuity of care delivery. Staff interviewed had a sound understanding of principles of aged care including dementia care and stated that they feel supported by the management team. Caregivers' complete competencies relevant to their practice. There is input from external specialist services and allied health professionals, for example, physiotherapist, hospice/palliative care team, district nurse, wound care specialist, mental health services for older persons, and education of staff is evident in resident files reviewed. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Westmar 2021 has a coordinated Covid-19 response that include cohorting of staff and residents in case of an outbreak. The facility provide onsite accommodation for staff should an outbreak occur.</p>
<p>Standard 1.1.9:</p>	FA	<p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>the requirements of the Code. An open disclosure policy describes ways that information is provided to residents and families.</p> <p>Relatives interviewed confirmed they are notified following a change of health status of their family member. This was confirmed in ten incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur six to eight-weekly. The residents stated that the owner/manager are on-site daily. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p> <p>The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Staff completed training in communicating effectively with residents with cognitive deficits and /or speech impediments (June 2021). Communication to families related to Covid-19 is provided in regular newsletters and individual emails are sent to relatives. Family members interviewed confirm they are updated with any changes in health of their relative and feel informed about the facility's strategy under the Covid 19 preparedness framework.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Westmar 2021 (Ltd) can provide care for up to 28 residents requiring rest home and dementia level of care. On the day of the audit there were 23 residents in total (including one on a younger person with disability [YPD] contract and one resident on respite care funded by Accident Compensation Corporation [ACC]). All other residents are under the Aged Related Residential Care contract (ARRC). This includes 16 rest home level residents across 21 beds and 7 residents in the 7-bed secure dementia unit.</p> <p>A partial provisional audit completed November 2021 verified the reconfiguration of beds across the rest home and dementia unit. It is intended that the dementia unit will increase from seven to 13 beds and the number of rest home beds will decrease from 21 to 15 including three double rooms which are used for single occupancy or couples. The total number of beds will remain at 28 beds. This configuration has not been implemented yet as not all findings had been addressed.</p> <p>The proprietors have owned/managed Westmar 2021 since May 2021. The two owners (spouses) are experienced directors/managers and have owned another rest home for the past six years. The owner/ facility manager (a comprehensive registered nurse) oversees delivery of care services (30 hours a week) and is supported by a second owner for daily operations, finance, and maintenance. The management team are also supported by two part time registered nurses (one a newly employed comprehensive nurse), enrolled nurse</p>

		<p>(EN) and qualified diversional therapist (DT).</p> <p>The service has a business plan for 2021-2022. The mission statement sets out the vision and values of the service and is displayed at the entrance to the facility and in the information pack. There are eight quality objectives that linked to the business plan and including (but not limited to); efficiency of care, safety of residents, responsiveness to the needs of the residents and accessibility to timely treatment. A business continuity plan and Covid 19 preparedness framework is integrated in all levels of the business plan.</p> <p>Both the managers have attended at least eight hours education around the management of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the owner/managers, the RNs will fulfil the role with support from the DT.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The owners/managers (clinical and non-clinical) advised that they are responsible for providing oversight of the quality programme. Interviews with staff confirmed their familiarity with the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed and updated by an external consultant. A suite of new policies were implemented in June 2021, however, there was no evidence that staff have read and understood the policies.</p> <p>A range of data (e.g. falls, incidents, infections, complaints, hazards, restraint, challenging behaviour, and medication errors) are collected, collated, and analysed monthly. Registered nurses interviewed advise these results are shared with staff, however, this is not always evident in meeting minutes. An internal audit programme schedule implemented for 2021 and being implemented for 2022 and consists of monthly audits on key components of the quality framework, however, there was no evidence in the combined staff/quality and health and safety meetings to verify staff were informed of the internal audit results. Audits include a</p>

		<p>monthly health and safety internal audits, medication management, pandemic preparedness, wound and restraint audits that is completed by designated staff in the facility including the DT (who completes non-clinical audits and adds internal audit information in the electronic system for all audits completed). A corrective action plan following internal audits is developed and implemented for areas that require improvement. Corrective actions were identified and signed off in a timely manner, however not all corrective actions were communicated to staff. Issues identified during meetings (combined quality/ health and safety/ staff and bi-monthly resident meetings) did not always have an action plan documented to address issues raised.</p> <p>Resident satisfaction surveys were sent out end on 4 February 2022 and data was still being collated at the time of the audit.</p> <p>The 2021 meeting minutes were reviewed and include discussions around Covid 19 preparedness strategies. Interviews with staff confirmed that meeting minutes are posted for them to read/review. Resident/family meetings take place six to eight weekly.</p> <p>A health and safety programme is in place that meets current legislative requirements. The owner (non-clinical) is the designated health and safety officer and has completed formal training in hazard identification and worksafe management. An interview with the health and safety officer and review of health and safety documentation confirmed that legislative requirements are being upheld. Internal audits related to the environment and equipment are completed monthly. Health and safety issues are discussed at the monthly combined staff/quality and health and safety meeting. External contractors and all new staff have been orientated to the facility's health and safety programme including Covid 19 preparedness requirements. The hazard register was up to date and was reviewed in August 2021 during a staff/quality meeting. A hazardous substance register is in place. Staff have completed annual manual handling and transfer education and competencies.</p> <p>Individual strategies are in place to prevent falls including sensor (buzzer) mats are used for those residents who are at risk of falling. These residents are checked frequently and are encouraged to be out of their rooms during the day so that they can be monitored more closely. Individual falls prevention strategies are implemented for residents that fall.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy that is being implemented by the service.</p> <p>Ten accident/incident forms were randomly selected for review. A registered nurse conducts clinical follow up of each adverse event. Neurological observations are conducted for unwitnessed falls and completed within the requirements of the policy. All adverse events reviewed demonstrated that appropriate clinical follow up, open disclosure and investigation took place. Adverse events are also reviewed and signed off by the owner (clinical). Relatives interviewed confirm they are informed of any incidents. Trends are identified on the</p>

<p>affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>electronic system (link 1.2.3.6).</p> <p>Discussion with the owners/managers confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided (e.g. police investigations, RN unavailability, pressure injuries). There has been no mandatory reporting required to HealthCERT since the last audit (March 2021). One respiratory outbreak in December 2021 has been reported to Public Health.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one DT, one RN, two caregivers, one housekeeper and one cook) showed appropriate employment practices and documentation. Three staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and suitability for the role. Current annual practising certificates are kept on file. Three new staff have not signed the Code of conduct /house rules document (link 1.1.7.3).</p> <p>The orientation package provides information and skills around working with residents with rest home and dementia level care. Orientation documentation are job specific and also key elements including health and safety, emergency preparedness, documentation and reporting, infection control including hand washing competencies.</p> <p>The annual training plan is implemented for 2021 and being implemented for 2022. The service has implemented an online training programme to supplement face-to-face training sessions to increase attendance. Mandatory training topics had been provided. Staff completed annual training in dementia related topics and challenging behaviour.</p> <p>The registered nurse (RN) is a Careerforce assessor and supports staff to complete education and obtain Careerforce qualifications. There is a total of 15 caregivers, who are encouraged to complete New Zealand Qualification Authority (NZQA) education. There are six caregivers with level 4 Certificate in Health and Wellbeing with dementia unit standards, two caregivers with level 3, and six caregivers with level 2. There are three registered nurses (including the owner), and two are competent in interRAI.</p> <p>Four (with level 4 NZQA) of eleven caregivers that works in the dementia unit have completed the required dementia standards and the other seven are in progress of completing (enrolment records sighted). The DT is a qualified diversional therapist and has also completed a formal course related to understanding dementia.</p> <p>Staff received first aid training in March 2021 and January 2022 and caregivers on afternoon, night shift and weekends have a first aid certificate. The RNs, both managers, DT [also van driver]) also have a current first aid certificate on file. Registered nurses are supported to attend external training.</p> <p>Staff complete annual competencies and include insulin, medication competency, second checker</p>

		competency, manual handling, and transfer (excluding hoist transfer), handwashing and restraint minimisation.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. One of the owner/managers is on site 30 hours per week and the other at least one day a week. The owner/managers are on call after hours for all issues and the registered nurses are on call for any clinical issues. Caregivers have access to the local ambulance service. Interviews with caregivers, residents and family members identified that staffing is adequate to meet the needs of residents. Management advised that extra staff can be called on for increased resident requirements.</p> <p>There is an RN on site every day of the week for eight hours a day and split their time between the rest home and dementia unit.</p> <p>The dementia unit 7 beds (7 occupied).</p> <p>AM: Caregiver 7am-1.30pm PM: Caregiver 3pm-11.15pm NIGHT: Caregiver 11pm-7am</p> <p>The rest home 21 beds (16 beds occupied) the residents are very independent and require low level supervision only.</p> <p>AM: Two caregivers from 7am-3.15pm, one caregiver will oversee the dementia unit during mealtimes and between 1.30pm-3pm PM: Caregiver 3pm-11.15pm NIGHT: Caregiver 11pm-7am</p> <p>All pm and night caregivers are medication competent, and first aid trained.</p> <p>There are two dedicated housekeepers who work from Monday- Friday (and cover a day each over the weekend while the current weekend position is vacant), kitchen staff, maintenance, and a gardener.</p> <p>The DT works Monday- Friday (30 hours).</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry, into the resident's individual electronic record supplemented by a paper-based file. Residents' files are protected from unauthorised access. Informed consent to display</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>photographs is obtained from residents/family/whānau on admission. Other residents or members of the public are not able to view sensitive resident information. Entries in records are legible, dated and electronically signed by the relevant caregivers or RN. Documents are archived on site in an appropriate secure room. Staff have access to the electronic file with an individual username and passcode. The business continuity plan include risk mitigation in case of an IT failure.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All residents are assessed prior to entry for rest home or dementia level of care. The service has specific information available for residents/families/whānau at entry and includes associated information such as the Code, advocacy, and the complaints procedure. There is specific information provided for families regarding dementia care. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Six signed admission agreements were sighted. The admission agreement reviewed aligns with the Aged Related Residential Care Agreement (ARRC) contract and other related contracts. Exclusions from the service are included in the admission agreement. Two files sampled in the dementia unit had NASC approval for the service and EPOA activation letters on file. Family members interviewed confirmed that staff had explained services to them on entry to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service. The yellow envelope system is used for transfers to hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>PA Moderate</p>	<p>Medicine management policies and procedures that meet legislative requirements are in place and implemented. The RNs and competent caregivers who administer medications complete annual medication competencies and education on medication is provided. All medication is stored securely. Fridge and air temperatures met requirements.</p> <p>The RN is responsible for medication reconciliation against the blister packs for regular and 'as required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. Unwanted or expired medications are collected by the pharmacy. Medicines (blister packs) are delivered monthly. Policies and procedures for residents self-administering are in place and this includes ensuring residents are competent and safe storage of the medications. Three residents were self-</p>

<p>guidelines.</p>		<p>administering non packaged medications and one resident was administering all medications.</p> <p>There are no medication standing orders in use.</p> <p>The service uses an electronic medication administration system. A medication round was observed; the procedure followed by the competent caregiver was correct and safe apart from the administration of the resident on respite care.</p> <p>Eleven individual resident's electronic medication charts were reviewed and one paper-based chart (respite). The electronic medication charts are identified with photographs, had been correctly signed and all discontinued medications had been signed and dated. All 'as required' (PRN) medications included indication for use and the effectiveness of as required medications was documented in the electronic medication system. There was evidence of three-monthly review by the GP, and allergies were recorded for all residents on the electronic charts, however, the resident on respite care did not have a current medication chart signed by a doctor.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Westmar 2021 are prepared and cooked on site. There are two cooks and one kitchen hand, and all have completed food safety education. The kitchen is based in the rest home with a servery opening out to the rest home dining area. There is a four-weekly seasonal menu which has been reviewed by a dietitian May 2021. Dietary needs are known with individual likes and dislikes accommodated. All food preferences are met. Fridge and freezer temperatures are recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents are recorded. A current food control plan is in place expiring 25 July 2022.</p> <p>Residents' nutritional assessment including likes and dislikes are identified and provided to the kitchen on admission. The cook interviewed is knowledgeable regarding specific residents needs including those with diabetes and unintentional weight loss.</p> <p>Meals are plated in the kitchen and delivered on covered trays to the dining area of the dementia wing. Meals are plated and directly served from the kitchen to the dining room in the rest home. The kitchenette in the dementia wing has storage for cutlery and a fridge for storage of fruit and other food items. On the day of the audit two staff were observed to assist with the meals in the dementia unit. Both dining rooms have enough space to move safely during mealtimes. Snacks are available 24/7 and special cutlery is available when needed.</p> <p>The resident/family annual survey was completed in March 2021 and general satisfaction was expressed with the food service. Residents and families interviewed expressed satisfaction with the meals provided at Westmar 2021.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents to the service is recorded. Should this occur, the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN completes an initial assessment on admission including risk assessment tools as appropriate. Relevant risk assessment tools including (but not limited to); falls risk, detailed pain, pressure injury, skin, continence, and nutritional assessments. An interRAI assessment is undertaken within 21 days of admission and reviewed every six months. Resident needs, support and goals are identified through the ongoing assessment process and form the basis of the long-term care plan. Residents interviewed confirmed their preferences and choices are accommodated.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Five of six resident files sampled all included a care plan and input from allied health. There was evidence of service integration with documented input from a range of specialist care professionals. Short-term needs are added to the long-term care plan when appropriate and signed off when resolved, however, not all care plans were reflective of resident's current needs. The interRAI assessment triggers and scores forms the basis of the long-term care plan. Assessment outcomes were included in the long-term care plans reviewed. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Activities assessments and plans were in place for all resident files reviewed.</p> <p>The two residents in the dementia wing files included a 24-hour activity plan and recreational plan with documented individual daily routine, behaviours, triggers, and activities to distract and de-escalate behaviours. The long-term care included specific medical risks and detailed behaviour management plan. Residents in the dementia wing have detailed behaviour plans to monitor behaviour and associated risks. The GP, dietitian and allied health professional progress notes were evident in the resident's files sampled. Any change in care required is documented and verbally passed on to relevant staff. The residents and relatives interviewed confirmed they were happy with the delivery of care.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Observation and interview with the RNs verified that care provided to the residents in the rest home and the dementia wing was consistent with their needs, however, one resident in the rest home had recent health deterioration and there was no evidence of a short-term care plan or updated interventions to support and direct staff to safely care for the resident (link 1.3.5.2).</p> <p>When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out.</p> <p>Specialised equipment including sensor mats, transfer belts, pressure relieving mattresses and cushions were available for use. Dressing supplies and continence products are readily available. There are sufficient stocks of personal protective equipment (PPE) to meet requirements. Staff received education in continence management in January 2021. Registered nurses interviewed were able to describe access to specialist services if required.</p> <p>Wound assessment and wound management plans were in place for three residents (across services). There were no residents with current or recent pressure injuries, one minor skin tear, one toe infection (seen by specialist wound care services) and one toe that had rubbed on the wall while sleeping. A resident on respite care had surgical wounds, but there was no wound care assessment or wound management plan completed (1.3.5.2). Wounds were recorded now in the electronic management system. Wound assessments, plans and reviews are current and completed. Interventions were undertaken in the stated timeframes. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed.</p> <p>There was evidence of monitoring including monthly (or more frequent) weight and vital sign monitoring, neurological observations, catheter changes, blood glucose levels, and behaviour charts in place. Food and fluid monitoring occur when required, however one rest home resident with weight loss, food and fluid charts were not maintained (link 1.3.5.2).</p> <p>The relatives interviewed stated that the clinical care is good and that they are involved in the care planning. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs,</p>	<p>FA</p>	<p>The diversional therapist (DT) is employed for 30 hours a week and has been in the role for 14 years, she is also responsible for completing the quality audits required in the facility. The DT is supported by two volunteers on the day she completes the facility audits. The DT is also supported by the care staff from the rest home and dementia wing to assist with activities. A resident profile is completed soon after admission. Each resident has an individual activity plan developed within three weeks, which is reviewed at least six-monthly.</p> <p>The DT develops a monthly activities calendar and includes but not limited to, resident favourites such as</p>

<p>age, culture, and the setting of the service.</p>		<p>housie, newspaper reading, word games, crafts, quizzes, exercises, manicures, and daily walks (weather permitting). Church services are held each Sunday, and communion is held for residents. The activities are provided from 8.30am to 3pm.</p> <p>The dementia wing usually has visitors between 3pm and 5pm and assist with activities. Activities are provided by caregivers over the weekends. A DT cupboard has been set up in the dementia unit to support caregivers completing activities with the residents. The DT has trained caregivers around providing activities with residents.</p> <p>The residents in the dementia wing have a 24-hour diversional plan to assist the caregivers in the individual's daily routine, specific behaviours, triggers, and de-escalating activities. On the day of the audit residents were observed being involved in newspaper reading and discussion. The rest home resident was participating in a Valentines quiz. All residents were celebrating Valentine's Day with a special morning tea. Being situated in a small community, close links with the community is ongoing and residents are supported to attend Library groups, Probus and Darfield Senior Citizen club. There are twice weekly sight-seeing (due to covid restrictions) outings available for rest home and dementia residents, and the DT accommodate residents' interests. The service receives feedback on activities through one-on-one feedback, residents' meetings, and annual surveys.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans for long term residents reviewed were evaluated by the registered nurses within three weeks of admission and long-term care plans developed. Progression towards goals are documented. The GP has reviewed residents three monthly. The resident/relative are invited to attend the multidisciplinary review with a manager, RN, caregiver, and DT. The GP on interview confirmed being notified of the six-monthly review. Assessments for short term changes in health are added to the long-term care plan and removed when resolved. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status. Progress notes reviewed identified regular reviews of residents. There was evidence of regular review by the RN.</p>
<p>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</p>	<p>FA</p>	<p>Westmar 2021 facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files and now in the electronic management system. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes, and confirmed with the GP on interview. There was evidence of referrals to the dietitian, physiotherapy, podiatrist, wound care specialist, older persons mental health, clinical nurse assessors and geriatricians.</p>

<p>appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented policies and procedures are in place for the management of waste and hazardous substances. Safety datasheets and products charts are readily accessible for staff. Chemicals are stored in a locked cupboard.</p> <p>Appropriate signage is displayed where necessary. Chemical bottles sighted were labelled correctly. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. Registered nurses and caregivers interviewed confirmed sufficient pandemic supplies are available. All staff have completed chemical safety training in November 2021.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 26 January 2023.</p> <p>The owner/manager (non-clinical) is responsible for maintenance and confirmed on interview that he has overall responsibility for building compliance. He completes maintenance requests and repairs, planned maintenance and gardens and grounds. A gardener has recently been employed to assist with garden maintenance. A maintenance folder is available and includes a record for preventative and reactive maintenance including interior and external building, electrical testing and tagging, calibration of clinical equipment, and monthly hot water temperatures. Hot water temperatures in resident areas are maintained below 45 degrees, however, hot water temperature had not been consistently recorded. Staff request for repairs are either verbal or via the maintenance request book. There is a 52-week planned maintenance schedule in place 2021, however there was no documented evidence of a planned maintenance schedule for 2022. Essential contractors are available 24 hours.</p> <p>There are sufficient supplies of equipment including (but not limited to); wheelchairs, oxygen concentrators, sensor mats, chair sensor mats, pressure relieving mattresses and equipment for clinical assessments such as thermometers and sphygmomanometers.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible promoting resident's independence. Corridors and public areas light and spacious and residents can walk around freely.</p> <p>The dementia unit is secure (link1.4.7.6). The dementia wing has an enclosed secure garden area which has a raised fence and safe walkway. There is seating and shade provided.</p>

		<p>There is a ramp to the front door of the facility. Outdoor areas have a maintained garden and patio areas with safe access. The facility has a resident van with current registration and warrant of fitness and can accommodate a wheelchair.</p> <p>The caregivers interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p> <p>Residents confirmed they are able to move freely around the facility and that the accommodation meets their need.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms throughout the facility have a handbasin. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Communal toilets and showers have a system that indicates if they are vacant or occupied. Fittings, fixtures, and flooring is appropriate. All rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Equipment/accessories are available to promote resident independence.</p> <p>All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms provide adequate room for residents to be provided with care and to safely manoeuvre using mobility aids. There are three double rooms in the rest home, currently there is a married couple occupying one of these rooms. Rooms viewed were personalised with residents own furnishings and adornments as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>In the dementia unit, there is a combined dining and lounge area to meet the dining and seating for relaxation requirements. There is also another lounge that can be used for quiet time. Activities occur at the tables or in the small lounge area in the dementia wing. The residents in the dementia wing can be taken through to the</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>rest home lounge for some communal activities such as entertainers.</p> <p>The rest home dining room is adjacent to the kitchen area and provides adequate space for rest home residents to enjoy their meals. There is a large lounge used for activities.</p> <p>All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required. There is a smoking area for residents outside of the building.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is completed on site. Cleaning chemicals are securely stored in locked cupboards and are labelled. Cleaning and laundry policies and procedures are available. There is a designated cleaner who completes the cleaning and laundry service. There is another staff member who assists with cleaning as required. The cleaning trolley is well equipped, and all chemicals are labelled. Protective wear including plastic aprons, gloves, masks, and goggles are available in the laundry. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties.</p> <p>The laundry has a clean/dirty flow. Internal audits monitor the effectiveness of the laundry service. Residents expressed satisfaction with cleaning and laundry services. The housekeeper interviewed could describe their responsibilities and procedures related to infection prevention and control.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>There is an emergency management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan. Fire evacuation drills are completed every six months. A contracted service provides checking of all facility equipment including fire equipment. Civil defence supplies are checked six-monthly with the last check occurring in December 2021. The facility has back-up lighting, a generator for power and sufficient food and personal supplies to provide for its maximum number of residents in the event of a power outage.</p> <p>There is also sufficient water stored to ensure for three litres per day for three days per resident. There are alternative cooking facilities available with a gas barbeque and gas cooker. The staff are responsible for checking the facility for security purposes on the afternoon and night shifts. The owners/managers maintain a list of staff and community numbers for emergency contact. The police would be summoned if/when required. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge, and dining areas. There is a staff member on each shift with a current first aid certificate.</p> <p>There is a secure door to the dementia wing, however this door has not yet been deactivated to include further six beds to the dementia unit as verified at the partial provisional audit.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. Electrical ceiling heating with thermostats in each room is the main source of heating. There are additional panel heaters and a heat pump in place. All resident rooms and the communal area have external windows that open, allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator (RN) has a defined job description that outlines the role and responsibilities. The RN has been in the role for three years and is supported by the staff. The infection control programme is approved and reviewed annually. Infection rates are discussed at monthly combined staff /quality and health and safety meetings (link1.2.3.6). Staff are made aware of new infections through daily handovers on each shift and reporting.</p> <p>There are adequate hand sanitisers placed throughout the facility. Adequate stocks of personal protective equipment were sighted. There is an implemented Covid-19 management plan according to alert level guidelines including QR code contact tracing. A visiting protocol is in place to ensure visitors are well when visiting the facility.</p> <p>Staff interviewed demonstrated an understanding of the infection prevention and control programme and were able to identify the importance of hand hygiene and using standard precautions.</p> <p>Covid-19 information is shared and accessible to all staff to read. There was a respiratory outbreak in December 2021 reported and managed appropriately.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and</p>	FA	<p>The infection control coordinator is responsible for infection control with support from the manger/owner, one other RN and the DT/quality person. The infection control coordinator has attended external education in the last year including hand hygiene and covid training. The infection control coordinator has access to infection control personnel within the district health board, infection control specialist, laboratory services and the GP.</p> <p>Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is available.</p> <p>All Covid-19 resources are integrated in the infection control/pandemic plan. All screening was adhered to, and records maintained. The service has been compliant with guidelines and documentation requirements</p>

<p>meet the needs of the organisation.</p>		<p>throughout the period. The entrance door to the facility is kept locked. All visitors require QR code contact tracing. All visitors are required to complete a wellness declaration, check temperatures, and use the hand gel when signing into the facility. Staff and visitors are required to wear masks. The staff and residents have received Covid-19 and flu vaccinations. Staff were observed to adhere to good handwashing practices.</p> <p>The facility has adequate stocks of PPE including N95 masks and rapid antigen tests (RATs). There is an isolation kit prepared and easily accessible to staff. The facility has a plan to manage a Covid outbreak. One area in the dementia wing has been designated as the area for residents with infection and there are two areas in the rest home that have been designated for residents with infections. These designated areas have outside access. Staff will work in designated areas only. The facility has staff accommodation on site if required.</p> <p>Residents and relatives interviewed reported that they were kept fully informed regarding covid updates.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two-yearly. Covid policies and plans have been regularly updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support</p>	<p>FA</p>	<p>All new staff receive infection control education at orientation, including hand washing. Infection control education is included in the annual education planner. Education was held around donning and doffing personal protective equipment, handwashing, and outbreak management in April 2021 and December 2021. The infection control person has completed infection control updates and provides staff education. Staff complete infection control training online (link 1.2.7.5). Education is provided to residents during daily support. Residents interviewed are aware of the Covid-19 requirements to minimise own risk. Residents are informed</p>

staff, and consumers.		in a timely manner of expectations and at six to eight weekly resident meetings of all appropriate infection prevention requirements.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control policies and procedure. Infection monitoring is the responsibility of the IPC coordinator. Short-term care plans are used. All infections are now entered into the electronic database, which generates a monthly analysis of the data. There is an end of month analysis with any trends identified. Outcomes are discussed at the combined staff meetings for quality/infection control/health and safety meetings, and daily handovers. If there is an emergent issue, it is acted upon in a timely manner. The infection control coordinator reviews each resident's infection and educates the residents and the staff as required. The GPs also monitor and review the use of antibiotics. A respiratory outbreak in December 2021 was managed appropriately and notification to Public Health was completed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraint or enablers on the day of the audit. Staff interviews and staff records evidence that education had been provided on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques for challenging behaviour. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint/enablers or challenging behaviour had not always been evidenced as discussed as part of quality/health and safety meetings (link 1.2.3.6). Internal audits include restraint minimisation.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.7.3</p> <p>Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.</p>	PA Low	As part of the employment policy, staff are provided and required to sign the Code of Conduct and House Rules – “All staff - the code of conduct and house rule” document, this has not been implemented.	Three newly employed staff have not yet signed a staff code of conduct document as required by the employment policy.	<p>Ensure staff received and signed the code of conduct document as part of the employment process.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and</p>	PA Low	The facility adopted a suite of policies and procedures by an external quality advisor in June 2021. Policies are available in electronic format. Caregivers confirm they have not read the policies as they felt it is difficult to navigate. The electronic system has a feature to capture an electronic signature whenever a staff member reads a policy, the facility	There is no evidence that staff have read and understood the	Ensure there is documented evidence that staff read and understood the

procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.		was unaware of this feature.	policies.	policies.  90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is a business plan available for 2021/2022 with eight quality objectives. Data is collated monthly in the electronic system and include falls, infections, wounds, complaints, hazards, medication errors, challenging behaviour, and restraint. Trends are identified and summaries are documented on the electronic system but not always evidenced as communicated to staff. Monthly meeting minutes evidence that only data related to falls, infection and medication errors are consistently communicated in meeting minutes. Corrective actions are documented and implemented following internal audit results, adverse events, and complaints but this has not always been discussed or communicated to staff during meetings.	(i). Not all quality data including trends and analysis are not always evident as being communicated to staff.  (ii). Internal audits results, non-conformities and corrective actions implemented have not consistently been evidenced as communicated to staff.	(i)-(ii)Ensure that all components of the quality programme are discussed and evidenced as communicated to staff.  90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective actions have been implemented and signed off in a timely manner following complaints, adverse events and internal audits but not consistently implemented for issues raised during meetings.	A corrective action plan following from issues raised during meetings (combined staff/quality and resident meetings) have not consistently been implemented.	Ensure corrective action for all key areas requiring improvement are developed.  90 days

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>Topics had been provided in 2021 but not limited to the following: informed consent, abuse and neglect, cultural awareness, falls minimisation, advocacy service, sexuality and intimacy, spiritual support, hazard management, dementia related topics, challenging behaviour, pandemic preparedness, nutrition and hydration, infection control principles and food safety.</p> <p>Staff completed the online modules, and the completed version is sent to the RN to check. An attendance register is completed when completed documents are received back, however this has not always been completed in a consistent manner.</p>	<p>(i). It was difficult to ascertain the attendance numbers for topics completed online.</p>	<p>(i). Ensure a consistent process of documenting attendance numbers for topics completed online.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Eleven electronic medication charts were reviewed. The electronic medication charts reviewed met legislative requirements. One resident on ACC respite had paper medication information including a doctor's prescription for medication on discharge from hospital. The resident had been at the facility for five days, and the prescription was three weeks old. On observation of the competent caregiver completing the medication round, the hospital prescription was being used as a medication chart to administer the blister pack medications. A separate signing sheet was used.</p>	<p>There was no current medication chart signed by a doctor to safely administer the resident's medication.</p>	<p>Ensure all residents have a current medication chart signed by a doctor.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>Long term care plans are resident centred, and evidence input from relatives (where appropriate) and allied health input where required. Short term care plans are implemented for short term resident needs, however, not all interventions were documented in a care plan.</p>	<p>(i). There were no current interventions documented in a care plan for the respite resident around a) management of a leg brace, b) the resident being non</p>	<p>(i). – (ii). Ensure all care plans contain current interventions to reflect residents' current needs and requirements.</p>

			weight bearing, and c) management of surgical wounds.  (ii). There were no current interventions documented for a rest home resident with recent weight loss.	90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The building has a current building warrant of fitness that expires 26 January 2023. The owner/manager is responsible for maintenance and confirmed on interview that they have overall responsibility for building compliance. Hot water temperatures in resident areas are maintained below 45 degrees, but not always consistently completed. There is a 52-week planned maintenance schedule in place 2021 but no schedule for 2022.	(i). Hot water temperatures were not consistently recorded. There were no documented recordings for 2022.  (ii). There was no maintenance schedule for 2022 and no documented planned maintenance signed as completed.	(i)-(ii) Ensure that all hot water temperatures are consistently checked and recorded and that the maintenance schedule for 2022 is actioned and planned maintenance completed.  90 days
Criterion 1.4.7.6 The organisation identifies and implements appropriate	PA Low	The current dementia wing is secure and the entrance door to the dementia wing needs to be relocated to include the further six bedrooms.	(i). The door to the current dementia unit is secured and will need to be	(i). The current door needs to be deactivated.  (ii). Ensure the

<p>security arrangements relevant to the consumer group and the setting.</p>			<p>disarmed. (ii). The new entry door is in place with a lock but not yet activated.</p>	<p>new relocated door is secure and activated to incorporate the extension of the six beds.</p> <p>Prior to occupancy days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.