

CSR Healthcare Limited - Heritage Remuera Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	CSR Healthcare Limited	
Premises audited:	Heritage Remuera Rest Home	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 5 December 2016	End date: 5 December 2016
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	23	

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

Heritage Remuera is part of the Kiwi Family Group Ltd (three facilities) and currently provides care for up to 33 rest home and hospital level care residents. On the day of the audit, there were 23 residents.

This audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess conformity prior to a facility being purchased. It comprised of an interview of the prospective new provider. The service recently had an onsite visit (certification audit) undertaken on 8 and 9 September 2016. The audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner. The facility manager (registered nurse) has been in the role for three years and is experienced in older persons' care management. He is supported by a clinical manager who has been in the role since January 2016. The current management team will be remaining in position with the new owner. The new owner is new to owning an aged care facility, but he is a medical practitioner and has been running his own medical centre since 2008. The new owners plan for the existing management team, staff and all policies and processes including quality and risk management systems to continue.

The service has achieved two continual improvement ratings relating to good practice and the food service.

Two improvements have been identified around documentation of wound care and the environment.

Consumer rights

The service provides care in a way that focuses on the individual resident. There is evidence that residents and family are kept informed. Care plans accommodate the choices of residents and/or their family/whānau. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. Informed consent processes are implemented. Complaints processes are implemented and complaints and concerns are actively managed and well documented. The rights of the resident and/or their family is understood, respected and upheld by the service.

Organisational management

The new owner is new to owning an aged care facility and will be take on a Directors role. The new owner has a transition plan in place to facilitate the smooth transition between owners with the least disruption of services for staff and residents which includes the ongoing employment of the current management team.

Heritage Remuera is implementing a quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Actions are implemented where a shortfall has been identified. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Registered nurses are responsible for the provision of care and documentation at each stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required. There is input from resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents three monthly and as needed.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Safe and appropriate environment

The building has a current warrant of fitness and emergency evacuation plan. Maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and some have shared ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounges and a dining area in the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. The maintenance staff are providing appropriate service. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had one resident using restraint in the form of bedrails and no residents with enablers.

Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

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	48	0	1	1	0	0
Criteria	2	97	0	1	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>Heritage Remuera has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Three caregivers, two activities staff, and two registered nurses (RNs) including one clinical manager, were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with seven residents (three rest home and four hospital).</p> <p>The proposed new owner demonstrated an understanding of the Code during interview</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Five resident files sampled demonstrated that advanced directives are signed for separately. There is evidence of discussion with family/EPOA when the GP has completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent</p>

		is obtained when delivering care. All five resident files sampled had a signed admission agreement signed on or before the day of admission.
<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>Advocacy information is available to residents in the service entrance. Interviews with residents confirmed they were aware of their right to access advocacy.</p> <p>Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family. Staff training in Code of Rights and advocacy has been provided.</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>Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community.</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>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager leads the investigation of concerns/complaints. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The service records all complaints received, this includes informal verbal complaints and written complaints. The complaints file was reviewed and there is an up-to-date complaints register. Eight complaints from 2016 were reviewed. All document that appropriate and timely responses have been documented. The service also completes a separate meal complaints log as part of an improving meals quality initiative (link CI 1.3.13.1).</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives and</p>

		residents are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Residents interviewed confirmed they received all the relevant information during admission. (No family were available for interview on the days of audit).
<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>There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection.</p> <p>Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings were documented in the five resident files sampled.</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>There is a Māori health plan and a cultural safety policy. Residents who identify as Māori have a culturally appropriate care plan. Linkages with Māori community groups are available and accessed as required through Greenlane Māori Group. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the resident's needs are being met. Discussion with residents confirm values and beliefs are considered. Residents are supported to attend church</p>

		services of their choice.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Job descriptions include responsibilities of the position and are in place for all roles within the service. The RN and allied health professionals practice within their scope of practice.</p> <p>Discussion with the facility manager and a review of the complaints register identify that there have been no complaints regarding alleged harassment, coercion, discrimination or abuse of any kind in the past year. Staff were observed to practice within their professional boundaries around the way they work with residents and all caregivers stated that there is definitely no evidence of abuse or neglect. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise. Interviews with the manager, the clinical manager, the registered nurse and care staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are robust policies and procedures in place that meet the health and disability safety sector standards. Staff state they are made aware of new/reviewed policies and sign to say they have read them. Staff report the manager and registered nurse are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RN has access to external training. Discussions with residents and family were positive about the care they receive. Kiwi Family Group have a clinical governance group that meet three monthly and review all infections, incidents and accidents, complaints and approve new policies. The service has exceeded the standard around good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The manager, clinical manager and registered nurse confirm family are kept informed. Files reviewed, document that family are notified promptly of any incidents/accidents. Monthly resident meetings encourage open discussion around the services provided (meeting</p>

		<p>minutes sighted).</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>There is access to an interpreter service as required.</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>This provisional audit was conducted to assess the preparedness of a new owner for the facility. The new owner is new to aged care. He is a medical practitioner and has been running his own medical centre since 2008. Interview with the new owner identified that his intention is to make no changes to management, staffing, policies or procedures including quality and risk management policies and procedures. It is the new owner’s intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. A business plan will be developed following the completion of the sale and the new owner intends to review the quality plan and programme with the manager going forward into 2017. The new owner intends to meet with the manager weekly.</p> <p>Heritage Remuera is currently part of the Kiwi Family Group. The service provides care for up to 33 rest home and hospital (geriatric) level of care residents. There are 18 dual-purpose rest home and hospital beds. On the day of audit, there were 23 residents. Six rest home residents were under the ARC agreement. Eight rest home residents included three younger person disabled, one Primary Options for Acute Care (POAC) resident and four residents under the long-term chronic condition contract. There were nine hospital level residents all under the ARC agreement. There were no respite residents.</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business. There are document quality objectives as part of a quality and risk management plan. The service has quality goals that are reviewed regularly. The facility manager has over five years’ experience in health and has been in the role at Heritage Remuera for three years. The facility manager is the clinical and quality manager for the group and</p>

		<p>reports monthly to the owners on a variety of management issues. The manager is supported by a clinical manager (registered nurse).</p> <p>The manager has completed at least eight hours of professional development including regional provider meetings.</p> <p>The management team is supported by the general manager.</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>The general manager (registered nurse) provides operational management in the absence of the manager. She will be supported by the clinical manager.</p> <p>With change of ownership the clinical manager will provide oversight when the facility manager is away.</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>	FA	<p>Heritage Remuera has a fully implemented quality and risk programme. There is a documented business plan 2016 / 2017, which includes KPIs around business and quality objectives. The service also has a risk and quality plan 2016. The combined plans have, as one of the objectives, to develop a robust quality improvement culture and also includes objectives such as a reduction in falls and the incidence of infections.</p> <p>Monthly reports from the manager to the general manager include evaluation and updates around the business plan. Monthly clinical and quality meetings also include reporting against the KPI and quality reporting each month. Sighted meetings evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include trends and graphs. Staff interviewed were well informed.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the InterRAI assessment tool.</p>

		<p>An internal audit programme covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A monthly summary of internal audit outcomes is provided to the clinical/quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety, and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirm they are kept informed on health and safety matters at meetings.</p> <p>There is a falls prevention and management policy in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Resident related accident/incident forms for the months of August 2016 were sampled. All document RN review and follow-up within a timely manner. Accidents/incidents were also recorded in the resident progress notes and changes to care plan had been documented as needed. There is documented evidence the family had been notified promptly of accidents/incidents.</p> <p>The service collects incident and accident data and reports aggregated figures to the clinical/quality meeting, and the health and safety meeting. Meetings documented that incident and accidents are discussed; this included care updates for each of the residents. Staff interviewed confirm that incident and accident data are discussed at meetings and information and graphs are made available.</p> <p>Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>FA</p>	<p>There are human resources policies to support recruitment practices. Five staff files sampled (three registered nurses including the clinical manager and manager, and two caregivers) contained all relevant employment documentation. Current practising certificates were sighted for the registered nurses. The service has an orientation programme in</p>

		<p>place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>An annual in-service education programme is in place with more training offered in the last six months. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with staff and a review of documentation demonstrate a commitment to the education of staff that is implemented into practice. Checks are documented. The registered nurses attend external training including sessions provided by the DHB with certificates on file to evidence this. This exceeds eight hours a year.</p> <p>There are implemented competencies for registered nurses related to medication with all relevant caregivers and the registered nurses (including the facility manager) having a current competency completed. There are also questionnaires completed in conjunction with training, for example, for restraint and infection control.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<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. The manager and nurse manager are on-site full time and available afterhours and an RN is on duty every shift. The caregivers and residents interviewed inform there are sufficient staff on duty at all times.</p> <p>The new owner does not intend to make any changes to existing management or staffing.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information are kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.</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>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager screens all potential residents prior to entry and records all admission enquires. Residents interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARC contract.</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>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require admission to hospital are managed appropriately and relevant information is communicated to the DHB. The facility uses the transfer (yellow) aged care envelope. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Resident's medicines are stored securely. Medication administration practice complies with the medication management policy, for the lunchtime medication round sighted. There are no residents self-medicating in the facility but one resident takes a blister pack home when on leave. The resident has been assessed as competent to do this by the GP. There are no standing orders.</p> <p>The facility uses a blister pack system. Medications are checked on arrival and any errors recorded and fed back to the supplying pharmacy. RNs give medications to hospital residents. Caregivers are permitted to give medications to rest home residents. Registered nurses and caregivers are medication competent. There is annual education provided. The medication fridge is checked weekly. Eye drops are dated when opened.</p> <p>Staff sign for the administration of medications on medication sheets held with the medication charts. Medication administration signing sheets correspond with prescribed medications. Controlled drugs are</p>

		<p>checked by two people and the register is checked weekly.</p> <p>Ten medication charts were reviewed. All charts were legible, up-to-date and reviewed at least three monthly by the GP. There was photo ID on each medication chart and allergy status was recorded. As required medication had prescribed indications for use.</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>	FA	<p>There is a well equipped kitchen and all food is cooked on site. There is one head cook who works Monday to Saturday 0900-1400. There are two kitchen hands that work 0700-1400 and cover Sunday. The evening meal is prepared by the head cook and the caregivers heat and serve it. There is a food service manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. The facility has recently introduced two options for residents to choose from at dinnertime. This was in response to requests from residents. Residents interviewed were satisfied with the quality and variety of food served. The service has exceeded the standard for meal services,</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their family where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly, or when there was a change to a resident's health condition. The InterRAI assessment tool is</p>

		implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The long-term care plans reviewed clearly described the support required to meet the resident's goals and needs and identified allied health involvement when required. The InterRAI assessment process informs the development of the resident's care plan. Residents interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
<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>	PA Low	<p>Registered nurses and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse or the mental health nurses). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient wound supplies and continence products.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents. There are currently two wounds being treated, one a chronic leg ulcer and one a skin tear of the right forearm. There are also two pressure injuries, one a stage four non-facility acquired (link hospital tracer 1.3.3) and one a stage two facility acquired. Not all wound management records clearly reflect on-going assessment/evaluation within the stated timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service and the ADHB wound specialist.</p> <p>Monitoring forms are in use as applicable, such as weight, observations, wounds and behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	A recreational officer works twelve hours a week. There is also an exercise coordinator who works twelve hours a week. The exercise coordinator runs an exercise class in the mini-gym daily. She also takes

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>residents on individual and group walks outside the facility. Each resident has an individual activities assessment on admission and an individual activities plan is developed for each resident by the recreational officer, in consultation with the registered nurses. These are evaluated six monthly at the same time as the long-term care plan. Each resident is free to choose whether they wish to participate in the group activities. Participation is monitored. There are a wide variety of activities offered. There is a large print activities timetable on the residents' noticeboard. On the day of audit, residents were observed participating in an exercise session and playing bingo enthusiastically. Residents who prefer to stay in their room have one-on-one visits for reading, hand massage and music.</p> <p>There is a van outing fortnightly. An entertainer visits weekly on a Wednesday. Special events like birthdays, Easter, Mother's Day and Anzac Day are celebrated. The facility is very close to a large shopping area and residents can walk to cafes and shops if able. Some residents attend Communicare. There are no church services on site but residents may go out to these and church visitors come in.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate the long-term care plan at least six monthly or earlier if there is a change in health status. The recreational officer evaluates the activities plan at the same time. There are at least three monthly reviews by the GP. All changes in health status were documented and followed up. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is on-going. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access with other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes.</p>

		Evidence of referrals were sighted on three files sampled.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are implemented policies in place to guide staff in waste management (link 1.4.2.1). Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>The building has a current building warrant of fitness. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are accessible and there are umbrellas available for shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The sluice room is not of an adequate standard and there is no designated clean clinical room.</p> <p>Interview with the new owner identified that he intends to repaint the facade next year and will review the preventative maintenance plan with the management team to determine what other areas need to be addressed.</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	In the rest home there are four rooms that share ensuites, ten that have a toilet and hand basin and one with a hand basin only. In the hospital (swing beds) there are two rooms which share a toilet and hand basin and sixteen which have a hand basin only. There are adequate communal showers and toilets. None of the communal showers are able to accommodate a shower trolley and the facility has no 'tilt' shower chairs. The service states that they are unable to accommodate residents who require these. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.

<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 residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas include one large lounge and dining area and several smaller lounges. These are large enough to cater for activities and these were observed taking place.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Caregivers undertake cleaning and laundry tasks. Once a week a contracted cleaner assists. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of the laundry and cleaning is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of the laundry and cleaning in the facility. Cleaning trolleys are stored outside the laundry but chemicals are removed and locked in the sluice room when these are not in use. Safety datasheets are available. Only personal laundry is done on site. The laundry is small but adequate and is divided into a 'dirty' and 'clean' area. There is a cleaning and laundry manual.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. There are torches and high-powered lamps for short-term back-up power.</p> <p>All staff have first aid training. There is a first aid kit, oxygen and suction</p>

		<p>available.</p> <p>There are call bells in the residents' rooms and these were observed to be within close proximity.</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>There are electric panel heaters in resident rooms, communal areas and hallways. All rooms have external windows that open allowing plenty of natural sunlight and ventilation.</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 clinical manager is the infection control coordinator. The infection control coordinator job description has identified delegated responsibility for infection control within the service. The infection control coordinator provides a monthly report to management and staff.</p> <p>The programme is approved and reviewed annually. Infection control is a standing agenda item at the monthly clinical/quality meetings (minutes viewed). Staff are informed about IC practises and reporting. There is a job description for the IC coordinator including the role and responsibilities. Infection control is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Infection control matters are taken to all staff meetings (minutes reviewed). The IC coordinator can access external DHB, IC nurse specialist, laboratories, and GPs specialist advice when required. The infection control programme is reviewed annually through the organisation. The coordinator complies with the objectives of the infection control policy and work with all staff to facilitate the programme. The coordinator has undertaken infection control training. Staff complete annual infection control education. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required.</p> <p>Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.</p>
<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 manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at monthly meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There has been no outbreak since 2015.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are in place, and include definitions, processes and use of restraints and enablers.</p> <p>There was one hospital resident with restraints (bedrails) and no residents with an enabler. The service practices environmental restraint with a keypad to the main exit door for the service. The keypad number</p>

		<p>is very visible next to the key pad. All five files reviewed had consent for environmental restraint.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>On-going consultation with the resident and family/whānau are evident. One resident file had an appropriate assessment for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures and monthly meeting discuss restraint and each resident with restraint as a set agenda item.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented</p>

		<p>as per the care plan on the resident with restraint file viewed.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for the one residents requiring restraint.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Evaluations are conducted three monthly and restraint use is discussed monthly at monthly clinical/quality meetings. One resident with restraint has documentation to evidence that the service has trialled the removal of the restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed as part of the organisation clinical governance group. Service level meetings include monthly review of restraint use. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Wound care assessment, wound monitoring, wound management and wound evaluation takes place. Two of four wounds do not evidence documented evaluations as part of the wound management documentation. Noting progress notes do identify wound reviews.	Two of four wounds management records do not been reflect assessments/evaluations being completed within the set timeframes. (Noting there was some documented evidence in progress notes to reflect dressing changes).	<p>Ensure wound management records reflect on-going assessment and evaluation</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs</p>	PA Moderate	The service has a sluice room; however it is not of an adequate standard. The service has a combined nurse's station and clinical room on the day of audit the nurse station was observed to be a high traffic area with all staff and a residents visiting the area. The staff	The sluice is set in a padlocked cupboard. The sluice room bench is lifting and poses an infection control risk (however advised this has been addressed post-audit). The service has a combined clinical room and nurse's station. The room is partially carpeted, the carpeted area included the nurse's desk, the resident fridge, the medication fridge, medication	<p>i) Ensure the sluice bench is replaced and complies with infection control standards; and ii) Ensure that there is a designated clean clinical room for storage of medication and clinical</p>

of the consumer/group.		stored bags and personal items in the room. This area also serves as the clean clinical room	trolley, wound care trolley and wound care stocks. The room also has a sealed floor area; this area contains the medication cupboard and medication preparation. On the day of audit, it was observed that the area was frequented by care staff, management, nurses and residents. Since the previous audit, the service assigned an area in the room as a clean area. However, the room is a multi-purpose room and there are a number of people in and out, which does not allow this area to remain clean or ideal for its purpose.	resources. 60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has developed a best practice approach to all aspect of clinical care. Staff interviewed were all aware of the resident centred approach, now fully implemented by the services.</p>	<p>The service has initiated a number of projects that have improved resident outcomes. This has included a clinical governance group for the five facilities. The group includes a consumer representative, a GP, the general manager (RN) a manager (RN) and a director. The group reviews all KPIs, reviews and documents all polices and has an active role in clinical governance for the services.</p> <p>Service specific improvements have included the implementation of a resident centred care plan and philosophy of care. It was identified by the management team in April 2016 that the service could improve the care plan to engender a holistic, comprehensive yet simple care plan template to effectively guide staff.</p> <p>An action plan was implemented that included: review of the previous care plan, audit of the care plan process,</p>

			<p>obtaining and including care staff input to both the old process and the new. The action plan reflects a high level of review, staff and senior management inclusion in the development of the new care plan. Training was also provided around the new process and mentoring for RNs regarding the documentation of the new care plan.</p> <p>Evaluation of the process has been positive with caregivers stating the care plan is very easy to follow and an appreciation of the need to read and follow direction in the care plan. Resident satisfaction has also improved around the domains of; 'staff understand my needs', 'staff are kind and gentle', 'I feel safe' and 'staff are trained'. Collectively these domains have improved from 72 % satisfied pre-implementation of the project, to 83% satisfied post-implementation.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RN and manager on duty. The kitchen staff have completed food safety training. The cooks follow a four weekly seasonal menu, which is reviewed by a dietitian annually and adapted to reflect resident preference. The service has exceeded the service standards for meal services</p>	<p>Because of feedback and a high level of complaints around meal services, the service reviewed meals, the kitchen and meal services. A plan was put in place to improve services.</p> <p>The plan included training for staff, purchase of a bain-marie, and a change to meal services. The service now offers two choices of main meal and two choices for dessert for the main meal at lunchtime. The cook serves the meal directly to residents from the bain-marie. Weekly review of the menu and suggestions from resident are acted upon and meals reflect resident preferences. The weekly menu has enticing names for the meals to encourage resident appetite. The puree meals have also been reviewed and are now presented in a very attractive manner. This accompanied with additional initiative such as high teas, toasted sandwiches, and adapting supper to the resident's preference has resulted in increased resident</p>

			<p>satisfaction.</p> <p>To effectively evaluate progress, the service separated meal complaints from other complaints. There has been a marked reduction in complaints regarding meals. Monthly meal surveys have been positive; have included a satisfaction rate of 68% for June 2016 to 100 % satisfaction for August 2016.</p>
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End of the report.