

# Chetty's Investment Limited - Alexander Lodge Rest Home

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Chetty's Investment Limited	
<b>Premises audited:</b>	Alexander Lodge Rest Home	
<b>Services audited:</b>	Rest home care (excluding dementia care); Residential disability services - Psychiatric	
<b>Dates of audit:</b>	Start date: 9 February 2017	End date: 10 February 2017
<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>	22	

# 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Alexander Lodge provides rest home level care and care for younger people with mental health disabilities. This certification audit was conducted against the NZ Health and Disability Services Standards and the provider's contract with the Auckland District Health Board (ADHB).

There have been no significant changes to the scope or size of the service since the 2015 surveillance audit.

The audit process included review of policy and procedures, assessment of residents' and staff files, visual inspection of the premises and interviews with residents, staff and the owner. A visiting social worker, a mental health nurse and relatives were interviewed on site and a general practitioner by telephone. All talked positively about their experiences with the service and expressed confidence in the quality and extent of care provided.

There were no improvements required as a result of this certification audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner`s Code of Health and Disability Service Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of the residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is provided and guided by a Maori Health Plan and associated policies.

There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open disclosure and communication between staff and families is promoted, and confirmed to be effective. There is access to formal interpreting and advocacy services as required.

The service has linkages with a range of specialist health providers, who contribute to ensuring services to residents are of an appropriate standard.

The complaints management system is known by residents and their families. There have been no serious or written complaints received since the previous audit. The service has immediately investigated and resolved a couple of verbal concerns raised by residents. Residents and relatives described the complaints system as fair, transparent and effective.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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All service delivery is overseen and managed by the owner with clinical input from a full-time employed registered nurse. The manager/owner is on site every day and has direct involvement in all aspects of the business and residents' care. A current business, quality and risk management plan is documented.

Alexander Lodge is maintaining a quality and risk management system and regularly monitoring all service areas. Quality improvements are documented when a need for improvement is identified and these are monitored for implementation. An external quality consultant reviews the system and visits on site regularly to provide support, advice and to carry out secondary audits of the services provided. The results of internal audits and regular satisfaction surveys of residents, their relatives and staff, reveal a high level of satisfaction and no concerns. The manager who is the appointed health and safety officer has completed external training and is conversant with the requirements of the new Health and Safety at Work Act. All staff have been informed about changes to the health and safety policy and processes.

Adverse events were being reliably reported by all staff. People impacted by an adverse event had been notified, for example, general practitioners and families. The service demonstrated there were effective systems in place to ensure all regulatory requirements were met.

Records and interviews showed that staff were being recruited and managed effectively. Staff training in relevant subject areas was occurring regularly. Staff reported they were supported and encouraged to attend ongoing performance development and achieve educational qualifications in health care. The service had evidence to show that an adequate number of skilled and experienced staff were on site 24 hours a day seven days a week.

Resident information is accurately recorded, securely stored and not accessible to unauthorised people. The sample of records are up-to-date, legible and relevant records are maintained. There is an archiving system and retrieval of records is assured should this be required.

## Continuum of service delivery

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.		Standards applicable to this service fully attained.
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The service providers work closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient detail and relevant information is provided to the potential resident to facilitate the admission.

Residents' needs are assessed by the nurse manager on admission. The medical practitioner reviews the resident within the required timeframes as per the service agreement. Shift handovers and effective communication provided ensures continuity of care is maximised.

Care plans are individualised. Short term care plans are developed to manage any problems that might arise. All residents' records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Family members interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health and disability services as required, with appropriate transfer and written handovers.

The planned activities programme is supported by the care staff. A variety of individual and group activities are provided. There are links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by the nurse manager or senior caregivers, all of whom have been assessed annually as competent to perform this role.

The food service meets the nutritional needs of the residents. Any special needs are catered for. Menu plans are available and dietitian input is used as required. The kitchen is well managed and organised, clean, and meets food safety standards.

## 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.		Standards applicable to this service fully attained.
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There was a current building warrant of fitness on display. The buildings and equipment are being well maintained. There was evidence of regular equipment checks and calibrations of scales, medical equipment and mobility aids.

Cleaning and laundry services were assessed as safe and hygienic.

Systems for emergency and essential services are in place and being monitored for effectiveness.

Upgrades and improvements to the environment since the previous audit include new floor coverings, bed replacements and an initiative that provided all residents with portable night lights to assist their safe mobility in the dark or in the event of power failure.

## 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 service was not using restraint interventions on the days of audit. The systems and practices in place for ensuring restraint minimisation and safe practice meet the requirements of the standard. On the days of audit there was one resident using an enabler. There is evidence that assessment, consent, approval and monitoring and reviews was occurring in relation to this enabler. Staff training around safer restraint and enabler use continues to be provided regularly.

## 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, is led by the nurse manager who has completed additional training, and aims to prevent and manage infections. There are terms of reference documented for infection control. Specialist infection prevention and control advice can be accessed from the District Health Board and laboratory services as required. The infection prevention and control programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures and supported with regular education provided monthly.

Aged care specific infection surveillance is undertaken, analysed, trended and benchmarked and results are fed back to staff. Follow-up action is taken as and when required. The infection control rate is very low for the facility due to the nature and size of the service.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Alexander Lodge Rest Home has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, and providing options to maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in the 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 give informed consent.</p>	FA	<p>The nurse manager and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Resident records reviewed show that informed consent has been gained using the standard multipurpose consent form including for (eg, outings, transportation, photographs for clinical purpose, and photographs for the medication and personal folders and for sharing information).</p> <p>Enduring power of attorney (EPOA) requirements and processes for residents unable to sign is defined and documented where relevant in the resident`s records. The nurse manager demonstrated understanding of being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<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>During the admission process the residents and family are given a copy of the Code, which also includes information on the Nationwide Advocacy Service. Additional brochures were available at reception/entrance to the facility. The nurse manager has the details of an advocate available to this rest home should a resident require additional support or advice.</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 assisted to maximise their potential for self-help and to maintain links with family and the community by attending a variety of organised outings, visits to shopping malls, activities, attending Zumba dancing classes in the community and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 clearly documented and effectively implemented complaints management process which meets the requirements of this standard, the provider's contract and complies with right 10 of the Code. Interview with the manager, review of the complaints register and documents related to the complaints logged since the previous audit, showed that the two minor matters on record were investigated immediately. The records and interviews showed that communication occurred with all the people involved and resolution was effectively and quickly achieved. A resident involved in one of these complaints was interviewed and expressed confidence in and satisfaction with the complaint process.</p> <p>Other residents and relatives interviewed confirmed they had received written information about complaints in their entry packs and in their agreements and that they were reminded about their right to complain at residents' meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Family members and residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service on admission to the service. The information is accessible in the information pack provided and on the reverse of the Code pamphlet. The Code is displayed throughout the facility in poster form and pamphlets together with information on advocacy and how to make a complaint are located in a drawer at reception. Feedback forms are also available.</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>	<p>FA</p>	<p>Families confirmed, and it was observed, that residents receive services in a manner that has regard for their dignity, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information that is not able to be overheard). All residents have their own room.</p> <p>The residents are encouraged to maintain their independence and to be able to move freely within their respective areas of the home. Outings with family are encouraged for residents that are able. Each care plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff interviewed understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is then provided on an annual basis, as confirmed in the staff interviews and training records.</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>	<p>FA</p>	<p>Staff support the three residents who identify as Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whanau to Maori residents. There is a current Maori Health Plan developed with the input of a cultural advisor. Current access to resources includes the contact details of the DHB advisors if needed. One family member interviewed has two family members in this rest home and they identify as Maori. Input was sought when they were admitted to this facility to ensure all needs were able to be met. Guidance on tikanga best practice is readily available and is supported by staff who identify as Maori in the facility. There is one staff member who identifies as being Maori.</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</p>	<p>FA</p>	<p>Family and residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents are able to attend the local churches if they wish. The service has Maori, pacific Islanders, Samoan and Tongan and Indian residents. Cultural needs and special days to celebrate different cultures occurs as part of the activities programme.</p>

values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The general practitioner interviewed expressed satisfaction with the standard of services provided to the residents. The staff induction process includes education related to professional boundaries and expected behaviours. The one manager has completed the required training on professional boundaries for meeting the requirements of the New Zealand Nursing Council (NZNC). Ongoing education is also provided on an annual basis which was confirmed in the staff training records. Staff are guided by policies and procedures and demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages good practice through (eg, staffing levels and managing challenging behaviour. The service aims to increase the health status of residents with mental health issues, support management of weight/exercise monitoring, and keeping residents healthy and well). The GP is new to this service and has a special interest in mental health and aged care. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education opportunities and the nurse manager is able to pursue her own professional networks to support good practice.</p> <p>Other examples of good practice noted was the activities programme and the strength of the palliative care/family/whanau support available. Family members interviewed are complimentary about the nurse manager and the care and support staff. The visiting mental health community nurse stated that this service is unique and provides a recognised service for the care of the residents placed at this facility.</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>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed through the DHB for the service when required. The staff represent a diverse range of cultures and staff can assist with interpreting as required.</p>
Standard 1.2.1: Governance	FA	On the days of audit the facility had 22 of its 23 beds occupied as one resident was in hospital. Two

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>residents were classified as young people with disabilities and four with ongoing mental health conditions. These six residents were under the age of 65 years. There was one resident registered as a private payer.</p> <p>Interview with the owner/manager and review of documents showed that quality, risk and business plans have current goals. Regular reports on service delivery and organisational performance is shared with all staff at their monthly meetings.</p> <p>The manager and RN's personnel files confirmed ongoing performance development in subject areas related to their roles. The owner has been in the role for almost four years and has in depth understanding of the industry and the RN who has been in the role for 10 years has extensive clinical experience in aged care.</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>Review of personnel files, interview with the manger, the RN and other staff confirmed that the manager's role is filled by the RN during planned and unplanned absences. The RNs role is filled by another RN who used to work at the facility and knows the residents and the systems.</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>The reviewed quality and risk management plan is aligned to the annual business plan and clearly describes the systems for service monitoring, review and quality improvement. Service goals for 2016-2017 are detailed and there was evidence in the management meeting minutes that progress towards these are discussed. Alexander Lodge have clearly recorded evidence of quality improvements made since 2015. These include improvements to the activities programme; change to the provision of pharmacy and GP services; the introduction of 'sugar free Fridays' to support residents who are following weight reduction regimes and to generally promote healthier eating; and the purchase of hand held night lights for each resident to maximise safe mobility at night or during a power outage.</p> <p>The owner has attended specific training on the Health and Safety at Work Act 2015, and staff have been informed about changes where these have been identified, specifically in the business and service policies.</p> <p>There is evidence that policies and procedures are being updated by the service as required and as part of the system developed by an external quality systems consultant.</p> <p>Minutes of residents' meetings confirmed that residents are consulted about service delivery and are kept informed. Resident satisfaction is formally surveyed annually and complaints records show communication</p>

		<p>and participation with the residents involved. Six residents interviewed stated they feel informed and are consulted about services in ways that they understand.</p> <p>Deficits that are identified by internal audits or any incident that requires remedial action to prevent recurrence is monitored for effective implementation by the owner/manager. There is documented evidence of corrective actions on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans identify all actual and potential risk to the business, service delivery, staff and/or visitor's health and safety. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk. There is a current hazard register and all risks and health and safety are discussed at staff meetings as confirmed by review of meeting minutes and interview with staff and management. The owner/manager is on site most days and is quick to mitigate against any risks to the business, resident or staff safety.</p> <p>Fire drills are occurring every six months. Residents interviewed confirmed they were fully oriented to the facility and received individual instruction on fire and emergency procedures. This was also documented in the six week post admission audit.</p> <p>Each resident has a documented risk assessment plan developed from information supplied upon entry to the service or from observations and assessments made during their stay. There is evidence these are reviewed six monthly or as necessary.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>The adverse event reporting system is coordinated by the owner and the RN and is known by staff who were interviewed. The event records reviewed on the days of audit showed that reporting on near miss and actual events occurs immediately. All events had been investigated to determine cause and actions taken to prevent or minimise recurrence. Service changes required as a result of the investigation are implemented as soon as practical. Staff, families and others who are impacted by an adverse event (for example, GPs, DHB) are informed in a timely manner. This is recorded on the incident form. There had been no serious incidents, no fractures or staff injuries. The majority of reported events in the previous 12 months were witnessed or unwitnessed falls, minor wounds (no pressure areas), two missed medications, and occasional altercations between residents. The total number of incidents in 2016 (18) was significantly less than the number in 2015 (29). This was attributed to the change in pharmacy, and staff diligence in preventing and minimising resident injuries.</p> <p>Review of policy and interviews with the manager confirmed an understanding of their obligations and requirements regarding essential notifications reporting. There have been no events which required notification since the previous audit.</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>Staff are managed in accordance with good employer practices and the service owner understands and complies with employment legislation. The skills and knowledge required is documented in position descriptions and employment agreements. All staff interviewed confirmed they understood their roles, delegated authority and responsibilities. Every job applicant is reference checked and police checked. Ten staff records contained evidence of curriculum vitae (CVs), educational achievements, and evidence of a current practising certificate for the registered nurse. New staff are oriented to organisational systems, quality and risk, the Code of Health and Disability Services Consumers' Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint minimisation, infection prevention and control and emergency situations.</p> <p>There was evidence in each personnel record that performance appraisals are conducted annually. Staff maintain knowledge and skills in emergency management, first aid certificates and competencies in medicine administration (all care staff administer medicines) and attend regular training in a range of subject areas including wound management and prevention of pressure injuries. The service supports all staff to engage in ongoing training and education related to care of older people and people with disabilities including mental health disabilities.</p>
<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>	<p>FA</p>	<p>The reviewed staffing policies adequately described the process for determining staff levels/skill mix and a staff and resident ratios protocol. The sighted staff rosters included appropriate levels of staff and skill mix.</p> <p>The registered nurse manager is employed full time and works Monday to Friday and is rostered on call, 24 hours a day and seven days a week. This person lives next door.</p> <p>Review of previous and future planned rosters show there is an appropriate number of staff on site at all times. Residents interviewed were satisfied with the availability of staff. Family members said they had no concerns about staffing. All the staff interviewed expressed job satisfaction and said there were enough staff with suitable skills and experience on all shifts. Interviews and personnel records reviewed showed a high staff retention rate. Alexander Lodge is not currently using bureau staff and most staff are willing to do extra shifts to cover for absences or when workload or resident acuity increases.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number is used on all labels as the unique identifier on all residents' information sighted. All necessary demographics, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical notes and integrated GP and allied health service provider notes are included. There are coloured divisions between each section to identify contents. The current records are kept in the locked nurses' office which is locked</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>when no staff are in attendance.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>Residents enter the service when the level of care has been assessed and confirmed by the local needs assessment and Service Coordination (NASC) Service or from the mental health services for older persons' specialists. Prospective residents and/or the family are encouraged to visit the facility prior to admission and meet with the nurse manager. They are also provided with written information about the services and the admission process. The service seeks updated information from the DHB and the GP for residents accessing respite care.</p> <p>Family interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Resident records reviewed contained assessments. Signed agreements were reviewed in accordance with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service facilitates transfer of a resident to and from acute care services as needed. There is open communication between the rest home and the DHB services, appropriate information, including the medication records and previous x-rays is provided for the ongoing management of the resident. All referrals are documented in the progress records and a copy of the referral letter is placed in the integrated records for the individual resident. The DHB 'Yellow bag System' is utilised effectively for transfers to the DHB. A transfer form is completed. Any risk are identified on the transfer form. Family are notified.</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 policy is current and identifies all aspects of medication management in line with the Medication Care Guide for Residential Aged Care.</p> <p>A safe system for medication management was observed during the audit. The staff member observed demonstrated good knowledge and had a good understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medications are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the nurse manager against the prescription. The pharmacist and the GP perform reconciliation of medications when the resident is admitted and as required through all stages of</p>

		<p>service delivery. The service has a new pharmacist contracted to provide the pharmacy requirements for the service. The pharmacists' annual practising certificates and the pharmacy licence has been verified. The GP and the nurse manager's annual practising certificates are also valid in relation to the medication management and competency evidence.</p> <p>There are no controlled drugs. The records of temperatures is maintained for the medication fridge. There is no separate medication room, but a locked cupboard is located in the main dining room for storing the blister pack folders. The registered nurse or the senior care giver holds the keys to access as required. The medication reviewed were signed, dated, can be verified by the master signature list sighted and designations were included. An internal audit has been completed by the nurse manager.</p> <p>Education has been provided to staff on 9 January 2017 on medication management. All senior care staff and the nurse manager complete medication competencies annually. All staff have completed first aid training and certificates were available.</p> <p>There are no residents who self-administer medications. There is a process should this be requested. There are no standing orders in 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>	<p>FA</p>	<p>The food service is provided on site by an employed cook and is in line with recognised nutritional guidelines for older people. A cook has been in this role for two years. The menu follows a summer and winter pattern and has been reviewed by a qualified dietitian within the last two years. Any recommendations from the last review have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has additional cleaning schedules developed and implemented. Food temperatures are monitored appropriately and recorded. The cook has completed safe food handling training in the last two years.</p> <p>A nutritional assessment is undertaken when the resident is admitted to the facility and a dietary profile is developed. The personal food preferences and special diets are made known to the cook. No residents are requiring any special equipment but it is available if required. There is no kitchen hand but staff assist in the dining room and are present throughout the mealtime.</p> <p>Evidence from interviews with family and residents verified satisfaction with the meals. Cultural needs are considered due to the diverse range of resident nationalities. The cook provides special meals as requested to meet the needs of residents. Functions are held regularly and the cook manages well with support of the staff, when catering for these activities and events.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whanau/family. Due to the nature of this service this rarely occurs. The NASC service and DHB work collaboratively together for each individual resident assessing this service.</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>Information is documented using validated nursing assessment tools such as the interRAI assessment. Other recognised tools are used by the registered nurse if needed such as; skin integrity assessment, nutritional assessment to identify any deficits and to inform care planning.</p> <p>The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by the nurse manager.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress records, activities records, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed onto care staff. Families reported participation in the development and ongoing evaluation of the care plans.</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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individual needs was evident. The GP interviewed verified medical input is sought in a timely manner that medical orders are followed, and care is managed to a high standard. Care staff confirmed that care is provided as outlined in documentation. A range of resources and equipment was available and suited to the level of care provided and in accordance with residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of</p>	FA	<p>The activities programme is provided by an activities officer who is required to implement the programme assisted by care staff. The activities officer has been in this role for three years and works Monday to Friday 9am to 11am and 1pm to 4pm and on Sundays to accompany residents, as required, to the local church.</p>

<p>the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>The activities officer has completed Careerforce training.</p> <p>The planned activities programme reviewed matches the skills, likes and dislikes and interests identified in admission data. Activities reflect residents` goals, ordinary patterns of life and include normal community activities, individual and group activities and regular events are offered. Music sessions, motivational activities and exercises to music are encouraged. The residents were observed completing exercises in the hallway using the safety rail with the activities officer leading the activity. The residents` interviewed confirmed they find the programme fun and interesting and enjoyable. Recent events are displayed around the facilities on the photo-boards. Activities are offered at the times when residents are mostly physically active and/or restless. The programme includes activities that are suitable for younger people as well as the elderly. This system has resulted in reducing medications, improved appetites and for some residents improved sleep patterns. Some residents go out and staff acknowledge they know their whereabouts. Van outings are available. The owner/operator maintains the licences of designated drivers, the warrant of fitness and registration of the vehicles available. A carer is also available for taking residents to appointments.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The care plan evaluations occur every six months in conjunction with the six monthly interRAI assessment or as the residents` needs change. Evaluations are documented by the nurse manager. Where progress is different than expected, the service responds by initiating changes to the care plan. Examples of short term care plans were consistently reviewed and evaluated at the clinically indicated timeframe stated on the plan (eg, daily or weekly) and according to the degree of risk noted during the assessment process. Families/whanau provided examples of involvement in evaluation of progress and any resulting changes.</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 appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access other health and disability service providers. Although the service has a resident doctor, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist advice or input. Copies of referrals were sighted in residents` records, including to radiology, mental health services, health services for older persons, the DHB NASC service, dietitians or other health professionals.</p> <p>Referrals are followed up on a regular basis by the nurse manager or the GP. The resident/family are kept informed of the referral process, as verified in documentation and family interviews. Any acute/urgent referrals are attended to immediately, such as sending a resident to be admitted to the renal service for an acute infection. Transportation is arranged according to the presenting circumstances.</p>

<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	<p>Policies and procedures related to waste are documented in accordance with legislation and local authority by laws. Staff interviews, observations and visual inspection of all areas revealed that there are no hazardous substances stored on site. Household and biological waste is disposed of appropriately. A sharps collection box is stored securely and incontinence products are placed in an outside receptacle for weekly collection and disposal. There is minimal food waste and the management of this and/or other organic waste complies with environmental guidelines. The RN stated there were no residents with known transmissible diseases and that all body waste is handled using standard and universal precautions. Kitchen and care staff were observed to be using hair nets, aprons and gloves when engaging in food handling, personal cares, cleaning or laundry tasks.</p>
<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>	FA	<p>Interview with the owner revealed that preventative and reactive maintenance occurs as required. A contracted 'handyman' lives close by who carries out repairs and maintenance work when required. The owner/manager works in with external contractors for medical and specialist plant and equipment checks. There is annual equipment checks and calibrations for scales, medical equipment (sphygmomanometer, thermometer) and mobility aids are conducted. Annual electrical testing and tagging occurs as required.</p> <p>A fire safety company visit monthly and equipment suppliers conduct regular checks. The manager carries out other building checks. The building warrant of fitness is current until March 2018.</p> <p>All external areas were inspected and assessed as safe and accessible.</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>There are sufficient numbers of suitably located toilets and bathrooms throughout the facility. Each bathroom and/or toilet had a functional locking system for privacy. All the bathrooms, excluding the upstairs bathroom are disability accessible. Each toilet and bathroom is fitted with hand rails, heaters, call bells and non-slip floors. All of the bedrooms have hand basins. There is a designated staff toilet. Hot water outlets are temperature tested each month. The test records and hand testing on the days of audit revealed safe temperatures under 45 degrees in resident areas and over 60 degrees Fahrenheit in the laundry and kitchen.</p>
<p>Standard 1.4.4: Personal</p>	FA	<p>The home has 21 bedrooms. Two are furnished as twin share rooms but only one of these was being</p>

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>shared at the time of audit. Agreement is sought from the residents and/or their families about sharing a bedroom. The maximum number of approved beds is for 23 residents. All bedrooms are of a sufficient size to easily accommodate a bed, easy chair, drawers, bed side tables and personal effects.</p> <p>The facility provides all the beds and bedroom furniture but residents are encouraged to bring their own furniture and personal effects into the home. Each room inspected reflected the personality and preferences of the occupant. The bedrooms for residents with mobility aids were clear of clutter or unnecessary furniture. There had been no recorded or reported incidents or issues related to personal space. Residents may request keys to lock their bedroom doors but there have been no issues about theft or missing personal effects. Residents interviewed expressed satisfaction and pride in their personal space/bed areas.</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 home has a large lounge downstairs and a smaller area upstairs which are used by all residents at different times of the day. Day time activities for residents who wish to participate are on offer in the downstairs lounge. The majority of residents also had televisions and radios in their room for individual relaxation or private time. There is a communal dining room and some residents choose to take their meals to their bedrooms. The home has plenty of external sitting areas and vegetable gardens which residents enjoy working in. Visitors tend to meet with residents in their bedrooms, or they take the resident out.</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>Cleaning and laundry is provided by the care staff who are each allocated daily tasks. The effectiveness of cleaning and laundry is audited regularly by the manager and resident feedback is encouraged. All areas of the home were assessed as clean and the relatives interviewed stated the home and their family's bedrooms were always clean and tidy.</p> <p>There was evidence that all staff had been provided training in the safe handling of cleaning chemicals. The chemicals were being stored safely and securely with the cleaning trolleys and equipment in a locked store room. Chemicals are decanted into clearly labelled containers from bulk dispensers. Material safety data sheets for each chemical is on site and located where the chemicals are stored. Laundry processes were observed to be effective, safe and hygienic. Care staff attend to the laundry needs (personal clothes, bedding) of the residents they care for each day. Staff stated they enjoyed doing this and that it did not impact negatively on their time with residents. The residents and family members interviewed stated they were satisfied and grateful for the cleaning and laundry services provided.</p> <p>There is no sluice room but the only residents requiring ready access to toileting in the night are allocated bedrooms with ensuite toilets. The majority of residents are continent and independent with attending to</p>

		their toileting needs.
<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>There is an approved fire evacuation scheme for the building and trial fire evacuations are occurring at least six monthly. The most recent fire drill occurred on 12 December 2016. The results of this were recorded; for example, how long it took to clear the building and any issues that arose. A hard wired fire suppression system (sprinklers and smoke detectors) are installed and exit signs are clearly displayed.</p> <p>A civil defence kit containing essential emergency supplies and equipment is on site and the contents are checked regularly. The facility is storing sufficient water and food for the needs of 23 residents for three days and has portable gas cookers and barbeque for cooking if required.</p> <p>The call bell system is functional, and staff were observed to respond to the bell immediately. Residents and family members stated staff were always attentive and responsive.</p> <p>Interview with the manager and staff confirmed that security checks of all doors and windows occurs each day at dusk. There have been no security incidents since the previous audit in 2015.</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>All areas of the home have sufficient natural light. Each bedroom has large opening windows and the majority of bedrooms downstairs have access to outside. The bedrooms are individually heated by recently installed, flat wall mounted panel heaters and hallways and communal areas are heated by gas. There are surplus quilts and blankets and piped gas on site for heating in the event of an electrical power outage. The residents interviewed confirmed the home was sufficiently warm and ventilated to suit their needs all year round. There was no evidence of complaint or issues with temperatures in the residents meeting minutes, in the complaints records or building maintenance logs.</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 service has a managed environment that minimises risk of infection to residents, staff and visitors, through the implementation of an infection prevention and control programme. The infection prevention and control programme is guided by the current infection control manual, developed with input of a quality consultant. The infection control programme is reviewed annually.</p> <p>The nurse manager is the designated infection prevention and control coordinator, whose role and responsibilities are clearly defined in a job description.</p> <p>Infection control signage is available if required. `Wash your hands` signage is in the staff bathroom and is displayed around the rest home. Staff interviewed understood their responsibilities related to infection control. Staff are also well informed about when to have sick leave and when to come back to work.</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>The nurse manager is an experienced registered nurse who also works at the DHB as well as working allocated permanent hours at this facility. The nurse manager has appropriate skills, knowledge and qualifications for this role. The annual infection control review was completed on 26 December 2016. The objectives were discussed with staff and how these are achieved. The nurse manager has established networks with the infection control team at the DHB who are available for expert advice, and the community laboratory is available if additional support and information is available. The recently contracted GP is pleased to be involved with any infection control issues that may arise.</p> <p>The nurse manager confirmed the availability of resources to support the programme and any outbreak of infection that may occur.</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 prevention and control policies and procedures reflect the requirements of the infection prevention and control standards and current accepted good practice. Policies were last reviewed in 2016 and include referencing. Care delivery, cleaning, and laundry is covered by the care staff and the kitchen by the full time cook and relief cook. Staff were observed washing their hands and using personal protective resources as required. Handwashing facilities are available around the rest home. Staff interviewed demonstrated knowledge of infection control policies and procedures and practice.</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>Education is outlined in the infection control programme plan. Education is provided at staff meetings held monthly by the nurse manager or the quality consultant. Minutes of the meetings were reviewed dated 25 July 2016 and 8 August 2016, for example. Interviews, observations and documentation verified staff have received education in infection prevention and control at orientation and that education is ongoing. Content of the training was recorded by the nurse manager and a record of attendance maintained. There has been no out breaks of infections since the last audit. Staff interviewed are experienced and fully informed of the process should an outbreak occur.</p>

		Education with residents is generally on a one to one basis and has included hand washing advice.
<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>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the infection form in the resident's individual record. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results are compared with the previous months results. Surveillance results are shared with the owner/operator who is on site most days and with staff via the regular monthly meetings and at staff handovers. Graphs are produced for visual display. Benchmarking externally provides assurance that infection rates in the facility are well below average for this sector and the nature of the service.</p> <p>Any new interventions required is discussed with the care staff to ensure implementation occurs.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation and safe practice policy contains definitions and information that is congruent with the requirements of this standard. It lists approved restraints as lap belts and bed sides. Policy includes processes for assessment, approval and consent, monitoring and review, evaluation and staff training.</p> <p>On the days of audit one resident had been assessed by a hospital occupational therapist as needing a 'T Bar' attached to the bed to facilitate getting out of bed. The restraint register lists the name of the resident, identifies the intervention as an enabler, the date it was approved and implemented and why, and the frequency of review. The risks associated are identified and its use has been reviewed annually as there was minimal risk. A consent form is signed by the resident and there are clear descriptions of the intervention in the resident's care plan and progress notes.</p> <p>Staff training and information in relation to restraint and enabler use is ongoing. Information about the restraint policy is provided to new staff during orientation and reminders about restraint or enabler use is mentioned at monthly staff meetings. The staff interviewed could clearly differentiate between a restraint and an enabler and understood their responsibilities in regards to safe use of restraints and enablers, although there have been no residents requiring restraints.</p>

## Specific results for criterion where corrective actions are required

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

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

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

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

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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.