

Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa

Introduction

This report records the results of a Surveillance 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:	Golden Age Rest Home Limited
Premises audited:	Albarosa Rest Home Camellia Court Rest Home Golden Age Retirement Village
Services audited:	Rest home care (excluding dementia care), Dementia care
Dates of audit:	Start date: 28 October 2014 End date: 29 October 2014
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:	119

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Golden Healthcare (GHC) Golden Age retirement village provides rest home and dementia level care for up to 135 residents accommodated in the Golden Age rest home unit and two secure dementia units. On the day of the audit there were 119 residents. There is a general manager across the Golden Healthcare Group and an experienced manager at each unit. The managers are supported by registered nurses in each unit, a Golden Health Care Group Quality Manager and Clinical Coordinator.

The service has addressed two of the three previous shortfalls around short term care planning and aspects of medications. Further improvements are required around care planning. This audit identified that improvements are required around caregivers completing the required dementia standards, wound management documentation, pain assessments and neurological observations post head injury.

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.	Green	Standards applicable to this service fully attained.
--	-------	--

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception areas. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout all facilities.

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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

Golden Healthcare group, including Golden Age rest home, Camellia Court dementia unit and Albarosa dementia unit, has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a number of meetings including quality and risk meetings. An annual resident and family satisfaction survey is completed and there are regular resident and relatives meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Benchmarking groups across the organisation are established for facilities that provide similar service levels. Benchmarking and audit data demonstrate that they have achieved good standards of care and service. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support. An improvement is required around caregivers working in the dementia unit completing the required dementia standards within the required timeframe. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Service delivery plans demonstrate service integration. Assessments and care plans are completed by the registered nurses. Short term care plans are utilised for changes in health status, such as infections and wounds, however this audit identified there is an improvement required around aspects of care planning documentation, wound management documentation, pain assessments and neurological observations post head injury. Care plans are goal oriented and reviewed at least six monthly. Residents and family interviewed described being involved in the care planning process and they were informed of any changes in health care status. Activities are varied, meaningful and include inclusion at local community and entertainment events. Activity plans contain goals and interventions to assist resident reach the desired outcome. The diversional therapists in the dementia units provide a structured and individualised plan for the residents across 24 hours. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are reviewed by the general practitioner three monthly or earlier if necessary. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. There are food service policies and procedures and a link to a dietician. All food is cooked on site and residents interviewed were very complimentary of the variety and choice of food available on the menu.

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.
--	--	--

The service has a current building warrant of fitness that expires on 1 July 2015 for all three buildings.

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.
---	--	--

There is a restraint minimisation policy that is applicable to the service. There are no residents that require the use of an enabler. There are no residents requiring the use of a restraint. Restraint training is included in the in-service education programme.

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.
---	--	--

The infection prevention & control co-ordinator uses the information obtained through surveillance to determine infection prevention & control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking against other similar sites within its organisation. The service managed three gastroenteritis outbreaks during 2014.

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	14	0	1	2	0	0
Criteria	0	37	0	1	2	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>D13.3h. a complaints procedure is provided to residents within the information pack at entry.</p> <p>E4.1biii. There is written information on the service - philosophy and practice for Dementia care - particular to Camellia Court and Albarosa dementia units included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. <p>The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with nine rest home residents and nine family members interviewed (four rest home and five dementia) confirms an understanding of the complaints process. All staff interviewed (six caregivers - two rest home and four dementia, three registered nurses, the clinical coordinator and three unit</p>

		<p>managers) were able to describe the process around reporting complaints.</p> <p>There is a complaints register for each unit. The 2013 and 2014 complaints were reviewed. Verbal and written complaints are documented.</p> <p>In the rest home there were four complaints received in 2013 and five (two verbal and three written) in 2014. The complaints register evidences that complaints are documented, responses recorded and the complainant signs the register once they are satisfied that resolution has occurred. All complaints reviewed for 2013/14 have been signed off by the complainant. All complaints have been managed and due process has been followed. Outcomes are documented and improvements made following complaints.</p> <p>In Camellia Court dementia unit there was one complaint in 2013 and three (one verbal and two written) in 2014. All complaints have been followed up, documented and resolved.</p> <p>Albarosa dementia unit complaints folder includes six complaints for 2013 and five (two verbal and three written) for 2014. All complaints have been actively managed with improvements actioned and resolved.</p> <p>Advised by the general manager and senior staff that a complaint has just been received from the Health and Disability Commissioner's office (20 October 2014). Advised that the resident has been transferred to another facility for hospital level (previous dementia level care). Due process and a full investigation is in progress.</p> <p>Staff meeting minutes confirm that the issues have been discussed and communicated to staff. Complaints process is displayed in the reception areas with complaint forms. Discussions with caregivers and registered nurses (RN) confirmed that concerns/complaints were discussed at staff meetings.</p> <p>The complaints have noted acknowledgement, investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants. Discussions with nine rest home residents and nine family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	<p>FA</p>	<p>There is an open disclosure policy which describes ways that information is provided to residents and families. There is an admission pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service. The pack includes a copy of the code of</p>

<p>effective communication.</p>	<p>rights. This information is discussed at entry and staff are available whenever the family members wish to discuss any aspect of service delivery. Family are involved in the initial care planning and receive and provide on-going feedback.</p> <p>Regular contact is maintained with family including if an incident or care/ health issues arises. Accident/incidents management procedures alert staff around frank open disclosure and their responsibility to notify family/next of kin of any accident/incident that occurs. The three registered nurses and the clinical coordinator interviewed stated that they record contact with family/whanau on the contact record. Contact records were documented in all files reviewed. Twelve incident forms (four rest home and eight dementia) for September 2014 reviewed identified that family were notified. Incidents/accidents are benchmarked against other Golden Health Care facilities and three other providers. Nine family members interviewed (four from the rest home and five from the dementia units) stated they were well informed and involved when needed in residents care. All nine rest home residents and nine family members (four rest home and five dementia) interviewed confirmed the admission process and agreements documentation were discussed with them. Family state the service provides an environment that encourages open communication.</p> <p>Discussions with six caregivers (two rest home and four dementia) identified their knowledge around open disclosure and reporting to registered nurses who in turn contact family. There are resident meetings held four times a year in the rest home where any issues or concerns to residents are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised. Family meetings are held four times a year in the dementia units. Annual family surveys are also completed. Family respondents in the December 2013 survey are more than satisfied with the service. There is a large communal lounge and dining area and smaller sitting areas in all three units where discussions can occur. Privacy and sufficient time for discussion can be obtained in residents rooms if needed. Staff wear name badges.</p> <p>Interpreter policy available to guide staff in how to access interpreter services for residents and family (via the district health board (DHB)). This information is provided in resident information packs.</p> <p>D12.1 Non-Subsidised residents/family 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>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b: Nine family members stated that they are always informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</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>Golden Age Rest Home Limited provides rest home and dementia level care for up to 135 residents, accommodated in the Golden Age rest home unit (up to 54) and two secure dementia units - Camellia Court (up to 41 residents) and Albarosa (up to 40 residents). The service is part of the Golden Healthcare Group (GHC) which operates seven facilities in Christchurch. On the day of the audit there were 119 residents. There is a manager in each unit and all are experienced in aged care. The rest home manager has been in her position for 10 years. Golden Healthcare organisation has a general manager who reports to the owner of all seven GHC facilities. The organisation employs a quality manager and a clinical coordinator who works across all facilities and provide support to the manager and registered nurses at Golden age rest home and dementia units.</p> <p>The GHC group is managed by an executive team comprising the owner/managing director, a general manager (present and interviewed during the audit), a business manager/human resources manager, an administration manager, a clinical coordinator, and a quality assurance manager. The mission statement for GHC includes: 'To provide quality care for the resident catering for their physical, mental, social, emotional and cultural needs in a residence where they are cared for as unique individuals who merit the highest respect'. The performance of the organisation will be monitored through the: annual audit plan, policy and procedure review, family surveys, resident/family meetings, staff meetings, incident/accident review, complaints management, risk management surveying, the quality management programme, staff appraisals and orientation, and the quality and risk management plan.</p> <p>Golden Healthcare group has comprehensive quality and risk management systems implemented across its facilities. There is an overall GHC group strategic plan for 2013 - 2018 which includes services, financial, occupancy, building repairs and maintenance, and staffing. The quality and risk management plan for Golden Aged rest home and dementia units for 2014 includes goals and objectives for:</p>

		<p>certification of the facility, health and safety, infection prevention and control, management of corrective actions, policy and procedure review, services to Maori, and family involvement. Additional quality improvement projects have been developed and are being implemented including falls prevention, reduction in falls and subsequent fractures. Other key objectives for each unit include resident focused services, high quality service appreciation, competent staff, harmonious workplace and continuing quality improvements. Annual reviews are conducted of the quality and risk programme - last conducted January 2014. Across GHC, benchmarking groups are established for facilities with similar service levels. Benchmarking of key clinical quality and incident data is conducted.</p> <p>GHC provides a comprehensive orientation and training/support programme for their managers. The GHC group senior team (Executive team, facility managers and registered nurses) meet two monthly with a separate Nurses Meeting held on the same day. Alternate months the executive team and facility managers meet. The manager is supported by the clinical coordinator, quality manager, HR manager and general manager. The organisation provides annual training for managers.</p> <p>E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p> <p>ARC, D17.3di (rest home): the managers (three) have maintained at least eight hours annually of professional development activities related to managing a rest home including audit process training, employment law training and business professional development. The Golden Age Group managers meet every two months for peer support.</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>	<p>FA</p>	<p>Golden Healthcare group has comprehensive quality and risk management systems implemented across its facilities. There is an overall GHC group strategic plan for 2013 - 2018 which includes services, financial, occupancy, building repairs and maintenance, and staffing. The quality and risk management plan for Golden Aged rest home and dementia units for 2014 includes goals and objectives for: certification of the facility, health and safety, infection prevention and control, management of corrective actions, policy and procedure review, services to Maori, and family involvement. Additional quality improvement projects have been developed and are being implemented including falls prevention, reduction in falls and subsequent fractures. Other key objectives for each unit include resident</p>

	<p>focused services, high quality service appreciation, competent staff, harmonious workplace and continuing quality improvements. Annual reviews are conducted of the quality and risk programme - last conducted January 2014. Across GHC, benchmarking groups are established for facilities with similar service levels. Benchmarking of key clinical quality and incident data is conducted.</p> <p>Policies and procedures are in place with evidence of review (January 2014). New or revised policies are available for care staff to read and sign that they have read and understand the changes. There is a two monthly senior team quality and management meeting. The quality manager and the unit managers all manage quality systems within the individual units. There is a quality committee in each unit which reviews all quality activities taking place in the unit. The quality programme is reviewed two monthly and annually and is being implemented. Information is reported through the two monthly quality and risk meeting and monthly staff meeting. The two monthly Q&R meeting discusses key components and standing agenda items and includes reports from each part of the service including kitchen, laundry, nursing/clinical, carers, infection control, management, activities, and quality programme. Progress of quality objectives are reviewed at the quality and risk (Q&R) meeting. Monthly staff meetings take place in each unit with agenda items including discussion and reporting on quality and risk meeting minutes, resident care, uniforms, incidents/accidents, infection control, audits, corrective actions, complaints, health and safety and education. There are two monthly registered nurses meetings (1 October 2014 minutes sighted). There are three monthly diversional therapist (DT)/activity meetings (1 August 2014 minutes sighted).</p> <p>Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is reviewed annually. Restraint and enabler usage is documented. Each month a monthly summary report is prepared by the unit manager and reported to the quality manager. Items include all complaints, compliments, hospital admissions, staff incidents/accidents, resident falls, skin tears, behaviours, medication errors, and infections. All quality data is collated and reported to the quality manager for analysis and review. Monthly and yearly statistical graphs are generated and comparisons made. Benchmarking occurs against other GHC facilities for dementia and also three outside providers for rest home, that provide similar service level care. These are readily available for all staff in the staff room and discussed at staff meetings as confirmed by registered nurses</p>
--	--

	<p>and caregivers interviewed.</p> <p>Internal audits are conducted in each unit. The audit schedule is the same for each unit except re audits for corrective action requirements. Audits conducted so far for 2014 in the Golden Age rest home, Camellia court and Albarosa dementia units include: resident admission satisfaction surveys, complaints management, resident files, medication management, clinical device calibration, resident admissions, cook follows menu, continence, DT/activities, staff files, staff training, restraint minimisation, wound management, recording systems and storage, resident privacy and confidentiality, infection prevention and control in housekeeping, standard precautions/hand hygiene, laundry and food services, waste management, exposure to body fluids podiatry and hairdressing, workplace hazards, incident and accidents, first aid and civil defence and safe and appropriate environment. Corrective action format is used for all audits, meeting minutes and reports. Corrective actions list all activities relating to the issue identified including current and newly developed. There is evidence that all corrective actions are completed and signed off when implemented. The quality manager also reviews all corrective actions to ensure completion and provides follow up with any outstanding issues.</p> <p>The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. The scope of the quality improvement meeting is comprehensive. There is a culture of quality improvements and on-going annual reviews.</p> <p>All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.</p> <p>Resident meetings for rest home residents occurs three monthly (minutes sighted for 15 September 2014). Four rest home family members interviewed are aware residents meetings are held. Family meetings in the dementia unit are held on a regular basis four times a year (3 October 2014 minutes sighted). Annual surveys are conducted for residents and relatives. Resident and family survey conducted in February 2014 with very positive results and responses. The service achieved 100% for the question "would you recommend this facility". Results are analysed for improvement opportunities. A newsletter sighted for October 2014 reports on information and feedback for residents and family. Newsletters are produced one/two monthly in each unit. All relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.</p>
--	--

		<p>D5.4 The service has policies/ procedures to support service delivery; policies and procedures align with the client care plans.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.2g: Falls prevention strategies such as use of sensor mats, falls risk assessments conducted, physiotherapy input, exercise programme, environment review including flooring, use of Vitamin D, footwear and beds, medication reviews, resident education and staff training on manual handling. The service has a focus on falls prevention 2014 with staff training and education implemented.</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>There is an accident/incident policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms by the registered nurses. The incidents forms are then reviewed and investigated by the unit managers or registered nurse as appropriate, who monitor issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and reported to quality and risk committee, staff meetings and then onto organisational management meetings.</p> <p>Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. The service appropriately advised the public health department regarding three gastroenteritis outbreaks 2014 (February and July).</p> <p>A sample of incident/accident forms were reviewed for September 2014 (four from each unit), and all identified that the next of kin were contacted or if family did not wish to be contacted. The incident forms for rest home residents included two falls, one skin tear and one medication error (not given). There is evidence of assessment and first aid provided, registered nurse follow up including development of short term care plans and wound care plans, review of risk assessments, review by GP and referral as appropriate (link 1.3.6.1). Contact is documented on either the progress notes or family contact sheet. Incident forms sampled for Camellia court dementia unit for September includes one fall with no injury, one bruise, one behaviour and one resident that went into the dementia unit through the adjoining door. Albarosa dementia unit incident forms sampled included one behaviour, one</p>

		<p>fall with a skin tear and two falls with bump/graze to the head. There is no evidence of neurological observations being carried out (# link 1.3.6.1). There is evidence of appropriate documentation and follow up of each incident by the registered nurses and final sign off from the manager of each unit. The forms includes a section to record family notification.</p> <p>D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificate of registered nurses are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. Nine staff files were reviewed including two registered nurses, four caregivers (two rest home and two dementia), two activities and one housekeeper. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in six of nine files reviewed - (three staff have commenced employment within the last 12 months and are therefore not yet due for annual appraisal).</p> <p>There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. The registered nurses complete a specific orientation for registered nurses. Interview with six caregivers (two rest home and four dementia) described the orientation programme that includes a period of supervision. The caregivers reported that supervision can be extended if needed. This was verified by the managers. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Each unit keeps their own records. Each session includes an attendance sheet and training content. In-service education is conducted every month following staff meetings with either self-learning tools (SLTs) for core topics, competencies completed or specific identified educational topics delivered. SLTs include but not limited to intimacy and sexuality, food handling and nutrition, dementia and challenging behaviour, infection prevention and control, health and safety, documentation, restraint minimisation, abuse and neglect, spirituality and death. Competencies include but not limited to fire warden, medication, wound dressings</p>

		<p>and neurological observations. For those staff members who are unable to attend education, a competency is completed. Education other than the core SLTs is provided according to identified learning needs. This could be for individual units or combined. Comprehensive records are kept. Interview with caregivers and three registered nurses advised that there is access to sufficient training. Medication competencies (including insulin, nebulisers and controlled drugs) are completed for all nurses and caregivers who administer medication. These are checked by the registered nurses. Education conducted for 2014 includes wound care, hearing aids, continence, medication management, fire evacuation, Maori culture, manual handling, chemical safety, outbreak management and norovirus, addictions' issues in the elderly and de-escalation, asthma and COPD, skin tears, diabetes, fire training, health and safety and emergency preparedness, code of residents rights, documentation, hand hygiene, restraint. Self-learning tools and competencies have been completed for dementia and challenging behaviours, documentation, abuse and neglect and discrimination, wound care, code of resident's rights, cultural safety and Treaty of Waitangi, infection control and restraint.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint, and insulin administration.</p> <p>E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.</p> <p>E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.</p> <p>E4.5f There are 18 caregivers who work in the Albarosa dementia unit - 13 have completed the required dementia standards, two caregivers have completed the standards awaiting marking. One caregiver commenced employment recently and two caregivers are in progress of completing the dementia standard and have been employed since 2012. There are 20 caregivers in the Camellia Court dementia unit - nine have completed the required dementia standards, eight are currently working towards completion and one has completed and is awaiting marking. One staff caregiver has recently commenced employment and one caregiver that has been employed since 2012 has not completed the dementia standards. This is an area requiring improvement.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. Care staff reported that staffing levels and the skill mix was appropriate and safe. Nine rest home residents and nine family members interviewed (four rest home and five dementia) advised that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that there is a registered nurse either on duty or on call at all times, and that at least one staff member on duty will hold a current first aid qualification. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Advised that the roster is able to be changed in response to resident acuity. Caregivers are employed across all three shifts -with two rostered on overnight in each unit. There is an RN employed for 40 hours per week in each unit. The RN's provide on-call cover to Albarosa, Camellia and Golden age facilities with support for the clinical coordinator and the unit managers. Diversional therapists provide activities programme in the rest home 0900 - 1530 Monday to Friday, in Camellia Court dementia unit there is 50 hours of activities time provided by two staff, and in Albarosa unit there are 44 hours of activities provided by one staff member with an additional 2 hours on both Saturday and Sunday provided by a carer in training. The service employs cleaners, laundry staff and kitchen staff including cook and kitchen hands. The managers each works 40 hours per week.</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>There are medicine policies and procedures for all stages of medicine management. The blister packs are delivered every four weeks. The pharmacist signs on the blister pack that the medications have been checked. The registered nurses checks medications on delivery against the drug charts and countersign the blister pack. Locked medication trolleys in each unit are stored in the unit treatment room. Eye drops are dated on opening and there are no expired medications. Designated medication fridges have temperature monitoring documented weekly. Thermometers in place allowed for daily visual checks. Each area had a controlled drug safe for the storage of controlled drugs. There was evidence of weekly CD checks. Controlled drugs are checked out by two persons and signed by two persons on the medication signing sheet. All returns to the pharmacy are kept in a locked room until collected. Biohazard sharps containers were in treatment rooms for the safe disposal of sharps.</p> <p>The medication charts are clear and legible and reviewed at least three monthly</p>

		<p>evidenced by GP signature on the drug chart and a review stamp in the resident's medical notes. There is a photo on each drug chart with allergies, adverse reactions and cautions noted. There is information on allergic reactions, signs and symptoms and treatment in the front of the medication administration folder. Registered nurses and medication competent caregivers undergo annual competency and medication training. One caregivers in each unit was observed administering medications and inhalers. They were compliant in the administration and signing of medications. There are no residents self-medicating.</p> <p>D16.5.e.i.2; Fifteen of sixteen medication charts (one rest home on respite care) reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.</p> <p>Nine residents interviewed and nine family members interviewed reported that they are informed of any changes to medication and receive education from the registered nurses and GP as to the medication use and any possible side effects.</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>There are two kitchens, one located in Golden Age rest home and one located in Camellia Court dementia unit. There are two cooks employed in Golden Age rest home kitchen and all meals are cooked on site. There are two cooks employed in Camellia Court Kitchen. This kitchen also supplies the meals for Albarosa unit and all meals are prepared and cooked on site. Meals for Albarosa South are transported in a hot box to ensure that meals remain hot.</p> <p>A nutritional assessment is completed on admission and a copy is kept in the kitchen. Copies of nutritional assessments for residents were sighted and these had been updated by the registered nurses when there has been a change to any residents' dietary needs. Residents are offered a range of beverages and fresh fruits.</p> <p>There is a list in each kitchen of those residents requiring dietary supplements. Dietary supplements were evidenced stored in fridges in both kitchens. Both cooks interviewed advised that dates are checked weekly to ensure they have not expired. Special diets include one gluten free, one diabetic, two purees and one puree meat.</p> <p>Kitchen fridge, food and freezer temperatures are monitored and documented daily in both kitchens.</p> <p>D19.2 staff have been trained in safe food handling. Education on safe food</p>

		<p>handling and nutrition has been completed 2014.</p> <p>Resident annual satisfaction surveys are conducted and include questions about the food service. Food service audits were conducted in each unit in July 2014. Scores attained were; Golden Age rest home 100%, Camellia Court 91% and Albarosa achieved a score of 92%.</p> <p>Lunch time meals observed in Golden Age, Albarosa and Camellia Court were well presented. Staff received education on food handling and nutrition in 2014.</p> <p>E3.3f, D15.2f: Additional nutritious snacks and beverages are available over 24 hours in the Camellia Court kitchen which staff from Albarosa can also access.</p> <p>Nine rest home residents interviewed in the rest home were very complimentary about the meals and stated they were offered alternatives if they did not like what was on the menu.</p> <p>Residents are weighed monthly or more frequently as directed by the registered nurse or dietitian. Monthly weights were observed recorded in seven of eight resident files (one rest home on respite care) reviewed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The previous audit identified that care plans did not address all identified needs. All eight files reviewed (four in rest home, two in each dementia unit) for this audit the long term care plan covers all aspects of holistic care and is personalised to the individual resident. The care plan includes but not limited to: personal hygiene, grooming, communication, mobility, rest and sleep, nutrition and hydration, elimination, skin integrity, respiratory function, medications, pain, social, spiritual, cultural and activities and interests.</p> <p>Dementia specific care plans are developed on admission following an initial assessment which also includes the following: mental state, behaviour, cognitive function. There is a detailed behaviour management report with alternative strategies for de-escalation and diversion. There is an activities plan that covers a 24 hour period and reflect activities that are familiar to the individual resident.</p> <p>Care plans evidenced family/whanau and resident participation where appropriate.</p> <p>One of two resident files reviewed in Albarosa dementia unit had evidence of interventions to guide care staff in meeting the resident needs. One of three rest home files had documented evidence in the long term care plan to support mobility.</p>

		<p>The previous audit finding and is still an area requiring improvement.</p> <p>E4.3 Four dementia resident files reviewed (two from Albarosa and two from Camellia Court) identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Eight resident files were reviewed (four from the rest home, two from each dementia unit). All identified that an initial nursing assessment and care plan was completed within 24 hours and seven of eight files identify that the long term care plan was completed within three weeks (one rest home resident is on respite care). There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes in two rest home files and three dementia files. This is an area requiring improvement. Seven of eight care plans evidenced evaluations completed at least six monthly (one resident is on rest home respite care). Activity assessments and the activities care plans have been completed by the diversional therapist or activities coordinator. The care being provided is consistent with the needs of residents however two residents (Albarosa dementia) with documented head injury incidents do not have evidence of neurological observations completed and three residents (one rest home and two Camellia dementia) with prescribed controlled drugs do not show evidence that pain assessments have been completed following exacerbation of pain. This is an area requiring improvement. This is evidenced by discussions with residents, families, caregivers, and three registered nurses. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical reviews. Residents' care plans are completed by the registered nurses. Care delivery is recorded and evaluated by caregivers or registered nurses in the progress notes at least at least daily in all three units (evidenced in all eight residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The six caregivers, clinical co-ordinator and three registered nurses interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Nine rest home residents interviewed and nine family</p>

		<p>(four from the rest home, three from the Albarosa dementia unit and two from Camellia Court) interviewed were complimentary of care received at the facility.</p> <p>The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment and wound management plans are in place for 21 wounds (nine dementia care and 12 rest home including one pressure area). The wound assessments include measurements, objectives, wound classification, exudate and condition of surrounding skin as evidence in one rest home and two dementia wound assessments sampled. This is an area requiring improvement. The registered nurses carry out wound assessments and senior caregivers have been competency assessed to carry out basic dressings.</p> <p>Continence management in-services and wound management in-service have been provided in 2014. Wound audit completed in May 2014 achieved 100% compliance in all three units and continence audit completed in March 2014 achieved 100% compliance in all three units.</p> <p>During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Diversional therapists provide activities programme in the rest home 0900 - 1530 Monday to Friday, in Camellia Court dementia unit there is 50 hours of activities time provided by two staff, and in Albarosa unit there are 44 hours of activities provided by one staff member with an additional two hours on both Saturday and Sunday provided by a carer in training each week. A diversional therapy profile is completed on or soon after admission and information gathered is included in the care plan. There is documented evidence that a 24 hour care plan is in each of the four dementia care files reviewed. Individual resident attendance records are maintained and a weekly progress report is completed. Residents are quick to feedback likes and dislikes to the diversional therapist in the rest home. The diversional therapy</p>

		<p>care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.</p> <p>Activities in all three areas are planned monthly by each of the diversional therapists. A copy of the monthly programme is displayed in each resident's room and on the notice board in each area. Outings occur in each area on alternate weeks.</p> <p>Church services occur four times per month in the rest home and twice weekly in Albarosa and Camellia Court.</p> <p>Activities are included in the programme which is more specific to men. These include a gardening box, darts, bowls and cards.</p> <p>Residents are able to participate in an exercise programme as part of the facility's falls prevention initiative. There is also reminiscing, crafts, music, pet therapy and a variety of activities to maintain strength and interests. Participation in activities is voluntary.</p> <p>Resident meeting for rest home residents occurs three monthly (September 2014). Nine family members interviewed are aware meetings are held. Family meetings in the dementia unit are held regularly (October 2014). Annual surveys are conducted for residents and relatives results are analysed for improvement opportunities (February 2014). All relatives interviewed stated they are regularly asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service.</p> <p>Caregivers and diversional therapists were observed at various times of the day interacting and assisting residents to join in activities which were occurring in Albarosa, Camellia Court and Golden Age rest home.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at the same time as the care plan review.</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>Six monthly multidisciplinary reviews (MDR) occur with the registered nurse, GP, diversional therapist. The family are invited by letter. If they are unable to attend they receive a phone call or letter with the outcome of the MDR. All those present sign a MDR form.</p> <p>Risk tools are reviewed at the six monthly review or earlier if there are health</p>

		<p>changes (# link 1.3.6.1).</p> <p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.</p> <p>Short term care plans were evidenced in use for infections, acute pain, wounds and medication changes. This was a previous audit finding that has now been addressed.</p> <p>ARC: D16.3c: Seven of eight initial care plans were evaluated by the registered nurse within three weeks of admission (one rest home resident is on respite care).</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>The service has a current building warrant of fitness that expires on 1 July 2015 for all three buildings.</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 control data is collated monthly and reported at the Q&R meetings and staff meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the Manager's report on quality indicators which is submitted to the quality manager. The surveillance activities at the units are appropriate to the acuity, risk and needs of the residents.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The service has a proactive approach around follow up actions of infections and clinical indicators.</p> <p>The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if</p>

		<p>there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting.</p> <p>There has been three gastroenteritis outbreaks at the rest home during 2014 (two confirmed noro virus). The first outbreak started 27 February and ended 5 March. Thirty one residents and 11 staff were affected. Two residents were admitted to hospital with dehydration. The second outbreak started 20 July and ended 27 July. Eight residents and three staff were affected. The third outbreak started 11 October and ended 13 October with five residents and two staff affected.</p> <p>There has been one outbreak in the dementia unit (Albarosa) which started 18 July 2014 and ended 25 July 2014 with 13 residents and nine staff affected.</p> <p>During each outbreak public health was appropriately informed and all data supplied. Staff were kept fully informed during handovers and families were notified through notices at reception and each family member sent official notification of the outbreak. Staff education has been provided from an external infection control specialist 7 August 2014 regarding outbreak and Norovirus management.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort.</p> <p>The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Currently the service has no residents requiring the use of a restraint or enabler. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.</p> <p>There is a restraint approval group that meets annually (October 2014) and reports to the quality improvement group. It is responsible for prior approval of each individual resident's use of any form of restraint.</p> <p>E4.4a The four dementia care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.</p> <p>Education on the management of challenging behaviours occurred 7 October 2014.</p> <p>Restrain audit is completed six monthly (April 2014 with 100 % compliance).</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There are 18 caregivers who work in the Albarosa dementia unit - 13 have completed the required dementia standards, two caregivers have completed the standards awaiting marking. One caregiver commenced employment recently and two caregivers are in progress of completing the dementia standard however both have been employed since 2012. There are 20 caregivers in the Camellia Court dementia unit - nine have completed the required dementia standards, eight are currently working towards completion and one has completed and is awaiting marking. One staff caregiver has recently commenced employment.</p>	<p>Three caregivers (one in Camellia and two in Albarosa) have not completed the required dementia standards within the required time frame.</p>	<p>Ensure that all caregivers working in the dementia units complete the dementia standards within the required time frame.</p> <p>90 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The long term care plan covers all aspects of holistic care and is personalised to the individual resident. The care plan includes but not limited to: personal hygiene, grooming, communication, mobility, rest and sleep, nutrition and hydration, elimination, skin integrity, respiratory function, medications, pain, social, spiritual, cultural and activities and interests.</p> <p>Dementia specific care plans are developed on admission following an initial assessment which also includes the following: mental state, behaviour, cognitive function. There is a detailed behaviour management report with alternative strategies for de-escalation and diversion. There is an activities plan that covers a 24 hour period and reflect activities that are familiar to the individual resident.</p> <p>Care plans evidenced family/whanau and resident participation where appropriate.</p> <p>The long term care plan includes medical diagnosis and problems including medications (reason, adverse effects, and cautionary notes for administration).</p>	<p>(i) One of two resident files reviewed in Albarosa dementia unit had no interventions in the long term care plan to support the residents identified needs.</p> <p>(ii) Two of three files in the rest home had no mobility section in the long term care plan and therefor no interventions to support the resident's mobility needs.</p>	<p>(i)Albarosa & (ii) Golden Age Ensure all interventions are detailed in the long term care plan and all sections completed to support resident needs.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or</p>	<p>PA Moderate</p>	<p>Eight resident files were reviewed (four from the rest home, two from each dementia unit). All identified that an initial nursing assessment and care</p>	<p>(i) Two of four resident files in the rest home and one of two in Albarosa do not show evidence of updating interventions in the long term care</p>	<p>(i) Golden Age / Albarosa: Ensure that long term care plan interventions are updated to support residents identified needs. (ii) Albarosa:</p>

<p>interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>plan was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. Seven of eight care plans evidenced evaluations completed at least six monthly (one resident is on rest home respite care). Wound assessment and wound management plans are in place for 21 wounds (nine dementia care and 12 rest home-including one pressure area).</p>	<p>plan to support resident health needs. (ii) Two residents from Albarosa with documented head injury on an incident form do not have neurological observations completed. (iii) Three rest home files reviewed of residents on controlled drugs do not have documented evidence of pain assessments when exacerbations of pain occur. (iv) Eight out of nine wounds reviewed in Albarosa and eleven out of twelve in the rest home have aspects of documentation not completed.</p>	<p>Ensure that neurological observations are completed for all head injuries. (iii) Golden Age Ensure that all residents with exacerbation of pain have pain assessments completed. (iv) Albarosa / Golden Age: Ensure that all wound documentation is completed.</p> <p>60 days</p>
---	--	---	---	--

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, 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

End of the report.