

Matamata Country Lodge Limited

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:

Legal entity: Matamata Country Lodge Limited

Premises audited: Matamata Country Lodge

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 19 May 2015 End date: 20 May 2015

Proposed changes to current services (if any): Since the last audit the service has converted one of the assisted living apartments to two rest home level of care beds, taking maximum capacity to 96.

Total beds occupied across all premises included in the audit on the first day of the audit: 71



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
	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

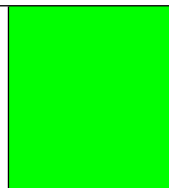
Matamata Country Lodge is an aged care facility that is part of the Cantabria Group of aged care facilities and retirement living villages. The service provides rest home and hospital level of care for up to 96 residents.

A full certification audit was conducted against the Health and Disability Services Standards and the services' funding contract with the Waikato District Health Board. The audit process included an offsite review of organisational policies. The onsite audit included the review of documentation and residents' files, observations and interviews. Interviews were conducted with management, staff, residents, family/whanau and a general practitioner to verify the documented evidence. This audit report is an evaluation of the combined evidence on how the service meets each of the relevant standards.

The service is meeting the requirements of all the standards and no systemic issues are identified at this audit. One of the strengths of the service is the way in which the quality and risk management systems are used to identify and address any shortfalls in the services and care delivery. The service proactively implements corrective and preventative actions to address any identified area for improvement.

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.

Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence is seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits every six months for staff education and attendance at residents' meetings. All staff interviewed were able to verbalise knowledge of residents' rights.

The service has a documented complaints management system implemented. There were no outstanding complaints at the time of audit.

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.

The organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs. The management team regularly review the business, risk and quality plans.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system included an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff. Reporting processes include external benchmarking so data can easily be compared to previously collected data and other aged care services.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. This allows residents' needs to be met in an effective, efficient and timely manner.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

There was no information of a private nature on public display. The resident's records are securely maintained.

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 organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are trained and qualified to perform their roles and deliver all aspects of service delivery. The nurse manager (NM) and clinical nurse leader (CNL) oversee the care and management of all residents, along with a team of staff. All residents are assessed on admission and assessment details are retained in the individual resident's records.

The residents' care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The residents and families interviewed reported they are involved in the care planning and review. The general practitioner (GP) ensures all residents are seen on admission and provides full medical cover for all residents 24 hours a day. Documentation is reviewed within timeframes as required.

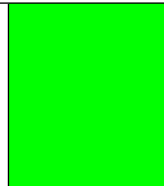
The activities available are appropriate for residents requiring hospital and rest home level care. An activities coordinator oversees the programme for the residents.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The NM and CNL are responsible for all areas of medication management and work alongside a contracted pharmacy.

Food is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed by a dietitian. Each resident is assessed by the NM or CNL on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. The two cooks have completed food safety training. Meals are provided at appropriate times of the day. Residents interviewed reported satisfaction with the food service provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

There are documented emergency management response processes which are understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness. There is an approved evacuation scheme and ongoing maintenance plans. The building is suitable for the needs of the residents. There are appropriate cleaning and laundry services.

The facility provides furnishings and equipment that is regularly maintained. There are adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs.

The building is suitably heated, cooled and ventilated. The outdoor areas, gardens and verandas provide furnishings and shade for residents' use.

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.

The service demonstrates that they are actively implementing strategies to minimise the use of restraints. All restraints and enablers are used to maintain the safety of residents. The approved restraints are bed rails and a lap harness. When enablers are

used they are voluntary and the least restrictive option to maintain the resident's safety and mobility. Restraint and enabler use is clearly documented in the resident's care plan.

There are appropriate processes in place to ensure that when restraints and enablers are used a sound assessment, review and evaluation process is occurring. The restraint minimisation committee monitors and approves all restraint use. As part of the internal auditing programme the service conducts six monthly quality reviews of their use of restraint.

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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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the infection control coordinator (ICC) who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Staff and residents are offered annual influenza vaccinations. There has been one reported outbreak of infection at the facility over the past twelve months.

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	50	0	0	0	0	0
Criteria	0	101	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme (sighted). Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents interviewed reported that they are treated with respect and understand their rights. The relatives interviewed reported that residents are treated with respect and dignity.</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>Evidence is seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring where applicable this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The</p>

		<p>consent can be reviewed and altered as the resident wishes. The NM discusses information on informed consent with the resident and family on admission. An advance directive enables a resident to choose if they would like active medical treatment to prolong life, transfer to base hospital for on-going treatment or receive 'comfort care'. The files reviewed have signed advance directive forms which meet legislative requirements</p> <p>Family members and residents are actively involved and included in care decisions as evidenced in residents' files reviewed.</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>Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons. This was confirmed in interview with residents.</p> <p>Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed report knowledge of residents' rights and advocacy service.</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 reported on interview that they are supported to be able to remain in contact with the community by outings and the walks to local shops and parks. Policy includes procedures to be undertaken to assist residents to access community services and a van is available.</p> <p>There is portable phone which is taken to the residents as required.</p> <p>Evidence in files reviewed shows attendance at DHB for appointments as required.</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>Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education. This was confirmed during interviews. Residents and family/whānau confirmed that the management's open door policy makes it easy to discuss concerns at any time. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur.</p> <p>The complaints and concerns register records all complaints and concerns, dates and actions taken. The complaints reviewed were addressed in time frames that complied with Right 10 of the Code. There were no outstanding complaints at the time of audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The policy details that staff will be provided with training on the Code and that residents will be provided with information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interview with the nurse manager (NM)). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Residents are addressed in a respectful manner and by their preferred names as was confirmed in interview with residents.</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>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed.</p> <p>Evidence is seen in files reviewed of the residents' goals which are personalised and reviewed every six months.</p> <p>Staff interviewed report knowledge of residents' rights and understand dignity and respect.</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>The plan includes a range of cultural issues/considerations for staff to be aware of. The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable.</p> <p>There were two Maori residents in the service at the time of audit and both reported on interview they are happy with the assessment of their cultural needs and receive recognition of individual needs as required.</p> <p>Education was given to staff on the Treaty of Waitangi in 2014 and staff interviewed reported that they understand the Treaty of Waitangi and attend the education annually.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>The NM or clinical nurse leader (CNL) assesses the cultural and/or spiritual needs of the resident in consultation with the resident, family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident.</p> <p>If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided as confirmed in interviews with hospital and rest home residents and review of satisfaction surveys.</p> <p>Staff interviewed reported on the need to respect individual culture and values.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed verbalise they would report any inappropriate behaviour to the NM. The NM reported she would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There is no evidence of any behaviour that requires reporting and interviews with residents indicate no concerns.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence is seen of care staff undertaking or having completed the National Certificate in the Care of the Elderly Education programme. All staff have an up to date first aid certificate (sighted) and all staff who administer medication have yearly assessments to determine competency.</p> <p>The CNL and RNs attend education sessions run by hospice and other local organisations. The planned yearly education programme reviewed included sessions that ensures an environment of good practice. The food service cooks have fulfilled the requirements of safe food handling. Residents' satisfaction surveys show evidence that they are satisfied with the meals and food supplied.</p> <p>Policies and procedures reviewed are all current and relate to best practice. There is specialist advice available if required.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to</p>	<p>FA</p>	<p>The cultural responsiveness policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, the senior staff member will offer the availability of the interpreting services to the resident and/or their family. These can be contacted via the DHB.</p> <p>Evidence is seen that all aspects of care and service provision are discussed with the resident and</p>

<p>effective communication.</p>		<p>their family/whanau prior to/or at the admission meeting. Staff make adequate time to talk with residents and families as confirmed in interviews with staff and the CN. There is sufficient space in each single room to permit private discussions and a telephone is available for the resident's use.</p> <p>Family members are used as interpreters, where appropriate, and with prior consent. If necessary, an interpreter within the community or staff is sought. This was confirmed in interview with the NM.</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>Care and services at Matamata Country Lodge are planned to meet the needs of the resident at rest home and hospital level of care. The service consists of a hospital wing, a rest home wing and an assisted living complex (ALC) apartment wing. There are dual purpose beds (can be used for either rest home or hospital level of care) in the rest home and hospital wings. All rooms in the ALC can be used for rest home level of care. At the time of audit there were 19 hospital level of care and 52 rest home level of care residents (this includes two residents in the ALC receiving rest home level of care). The residents in the ALC are in rooms that are closest to the rest home wing. Matamata Country Lodge is located within a wider retirement living village that also provides independent living villas.</p> <p>The overarching purpose, values, scope, direction, and goals are set by the Cantabria Group of aged care and retirement living complexes. Strategic planning is identified in the 2015 strategic and business plan. The Cantabria owner and management team review performance against the goals and direction at their three monthly management meeting. The vision and mission statements of the organisation are documented and displayed throughout the service. Risk management is included in the business and strategic planning processes and is monitored three monthly through the organisational management meetings. The owner and organisational management team have the overall role of governance and strategic direction.</p> <p>There is a nurse manager that is responsible for the clinical aspects of service delivery. The nurse manager has been in the role since March 2015, has previous experience in aged care management and has been a manager for the Cantabria Group previously. The nurse manager is a registered nurse (RN) with a current practising certificate. Job descriptions identify the nurse manager's experience, education, authority, accountability and responsibility for the provision of services. The group manager reports confidence in the nurse manager to undertake the clinical management role. The nurse manager participates in ongoing education to ensure they have at least 8 hours of education related to the management of aged care services.</p> <p>Resident and family satisfaction surveys, and interviews with residents and family at the time of audit demonstrate that residents and family/whānau are satisfied with the care and services provide at Matamata Country Lodge.</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>	<p>FA</p>	<p>The clinical nurse leader (CNL) undertakes the nurse manager's role during temporary absences. The group manager and nurse manager report that the CNL has extensive experience in aged care and they are confident in the CNL's ability to perform the nurse manager role during temporary absences.</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>The service has a quality and risk management system which is understood and implemented by the staff. There is a quality plan and a risk management plan. These include the development and updates of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. All reporting is linked to monthly benchmarking with an external aged care consultancy agency. This information is used to inform ongoing planning of services to ensure resident needs are met.</p> <p>Policies and procedures have been developed by an aged care consultancy agency. These are personalised to the service by the manager. The policies have been updated at least two yearly, or sooner if there was a change in legislation or best practice.</p> <p>The quality improvement data is collected, analysed and benchmarked. The internal auditing plan covers all aspects of service delivery, including residents' care planning, the environment, infection control, resident and relative satisfaction. The internal audits sampled evidenced corrective planning to address any shortfalls. Feedback is provided to the appropriate levels of staff, for example food services to the cook, clinical audit outcomes to the caregiving staff.</p> <p>The service also has quality improvement forms based on suggestions from staff, residents and visitors for areas that can be improved on. The forms sampled record the improvement implemented and follow up of the evaluation the effectiveness of the improvement.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.</p> <p>Actual and potential risks were identified and documented in the hazard register. There were interventions implemented to either eliminate, isolate or minimise the hazards. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and</p>

		implemented documented hazard identification processes.
<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>	FA	<p>Management understands their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. There have been no incidents or accidents that have required essential notification. A recent infection outbreak was reported to the DHB. Staff reported they report and record all incidents and accidents.</p> <p>Incident and accident reporting processes are well documented and any corrective actions to be taken were shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Family/whānau confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Falls management strategies are implemented for residents who have falls.</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>	FA	<p>Staff that require professional qualifications and annual practising certified (APCs) have these validated as part of the employment process. A register is maintained of the staff and contractors who require an APC, with current APCs sighted for all who require them.</p> <p>Policies and procedures are implemented for human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles. The residents and families report that the stability of the staff is one of the strengths of Matamata Country Lodge, stating that the staff get to know them and their needs really well.</p> <p>Staff undertake training and education related to their appointed roles. Records of attendance and competency training is maintained. Education provided is refined to current accepted good practice, with staff providing feedback and evaluation of the in-service education provided. The education programme covers the contractual requirements, staff competencies and specific issues related to the aging process. The service has completed the required RN training on the interRAI assessment tool.</p>
Standard 1.2.8: Service Provider	FA	Policy identifies staffing levels and skill mix are maintained to meet residents' needs and to comply

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>with the funder's contractual requirements and safe staffing guidelines. Rosters identified that at all times there are adequate numbers of suitably qualified staff on duty to provide safe and quality care. A review of rosters showed that staff were replaced when on annual leave or sick leave. There are appropriate numbers of administration, activities, maintenance, cleaning and laundry staff to meet the needs of the service and residents.</p> <p>The nurse manager reported that additional staff would be rostered to meet residents' needs and this was confirmed by staff interviewed. This occurred during a recent infection outbreak. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. The retirement village is staffed separately from the aged care facilities. Residents stated their needs are met in a timely manner.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Information is entered into the resident information management system in an accurate and timely manner. Records and archives are securely stored onsite. When required, records were appropriately destroyed.</p> <p>The progress notes were legible and the name and designation of the staff member. All records pertaining to individual residents were integrated, with evidence of the multidisciplinary team having input into the residents' care. Information of a private or personal nature is maintained in a secure manner and was not publicly accessible or observable at the time of 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>	FA	<p>An 'Admissions Policy' was sighted and includes the procedure to be followed when a resident is admitted to the home. The New Zealand Aged Care Association (NZACA) standard Resident's Services Agreement is provided. Entry screening processes are documented and communicated to the resident and their family to ensure the service is able to meet the needs of the resident.</p> <p>The residents and family reported on interview the admission agreement was discussed with them prior to admission and all aspects are understood.</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>	FA	<p>There is a specific transfer form to document information involving the resident to the WDHB or other facility. The form highlights any known risks, such as falls, includes current medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate. When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current treatments and</p>

		observations. A verbal handover is given by the CNL or RN on duty. Communication is maintained with the family as confirmed on interview.
<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>	FA	<p>The medication management policy provides guidance on medication reconciliation, prescribing, ordering, checking, storage, administration, and documentation of medications. The process for disposing expired/unwanted medications is also noted. Where a resident refuses medications this is documented and communicated. Errors are required to be reported via the incident reporting system. The management of controlled drugs includes weekly checks of balance and six monthly quantity stock count. Residents can be assessed as safe to self-administer medications. The assessments are repeated on at least a three monthly basis.</p> <p>Matamata Country Lodge uses the robotic medicine system whereby medicines are delivered monthly except for 'PRN' (pro re nata – as required) medication which are delivered as required. When the robotic medicines are delivered they are checked by the RN and evidence is seen of this on the signing sheet.</p> <p>There is evidence in files reviewed that medication charts are reviewed three monthly by the GP or as required.</p> <p>Standing orders are not used at this facility.</p> <p>The RN reports that the GP works with the pharmacy but he is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he charts this on the medication sheet.</p> <p>The RNs and competent caregivers are responsible for all medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines. Lunchtime medication rounds were observed on both days and complied with standard requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food services manual identifies a dietary assessment is conducted when a resident is admitted to identify any dietary needs and food preferences. The policy details the principals of food safety, ordering, storage, cooking, reheating and food handling. Staff infection prevention and control requirements are also detailed. Guidance is provided on pureed diets, soft diets, diabetic diets, light diet, reducing diet and a normal diet. Staff take into consideration the patient's preference regarding meal portion sizes, they also ensure residents remain appropriately hydrated. Practices to clean the kitchen and associated equipment is included.</p>

		<p>Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans. Residents report they are satisfied with the food services and given choice of foods to cater for dislikes and preferences.</p> <p>The service is managed by two cooks over seven days. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. All cooks are up to date with their food safety certificates. Evidence is seen of attendance at annual update education on infection control and first aid. The cook reports on interview that she is supported by management with food supplies and understands the individual requirements of the residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The NM reported that the needs assessment team at WDHB usually ring and a telephone discussion verifies the suitability for admission before the family visits, if the resident is in hospital. There is a folder which contains documentation of all enquiries and the action taken if the admission is declined. This included contacting the referral agency.</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>The initial nursing assessment includes good use of clinical tools, and these include falls risk, pressure area, and pain assessment. Referral letters are sighted from external agencies, including WDHB clinics, and there is evidence of family involvement in the assessment process. Evidence is sighted in files reviewed that assessments are conducted within the specified timeframes. In files reviewed, the assessment information is used as part of care plan development.</p> <p>The CNL reported that she oversees all care plans and residents and family are included.</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>In files reviewed evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and pain management.</p> <p>All health professionals document in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files reviewed include nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with</p>

		<p>them. Care staff reported they are informed of any changes to care plans at shift changeover.</p> <p>The CNL accompanies the doctor on his rounds and the doctor sends his visits notes are computerised and are printed in the files. The care plan is written in a language that is user friendly and able to be understood by all staff. In residents' files reviewed there is evidence to demonstrate involvement in care planning of the family.</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>In the files reviewed there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated as required and timeframes to ensure residents' desired outcomes are being met. Evidence is seen in documentation of a resident whose falls risk assessment had changed from a low to medium risk. Changes to the care plans included regular checking of the resident, leaving the resident's bell accessible and use of a sensor mat.</p> <p>The clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required specific to any new intervention</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>	FA	<p>There is a diversional therapist and activities coordinator employed at Matamata Country Lodge. Both work full time and activities are available in the weekends as the care staff undertake activities during the hours when the activity staff are not on site.</p> <p>The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the diversional therapist and activities coordinator reported they are in the process of reviewing the programme to ensure that all residents have access. This includes reviewing the times and area of the facility that the activity is held.</p> <p>External visits for the residents include beach and van trips. The residents reported on interview that the activities are positive and include exercise and music. Favourite activities are reported to be the visits of animals, day cares, schools and entertainment.</p> <p>The lifestyle care plan is completed and reviewed six monthly. Evidence is seen of monthly resident meetings and annual resident satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</p>	FA	<p>Individual short term care plans are seen for wound care, infections and weight loss. These are kept in the resident's folder and each shift documentation is made in the file as required. These are transferred to progress notes when completed or transferred to the long term care plan.</p> <p>Long-term care plans are reviewed every six months or earlier as required. Evidence of this was</p>

<p>and timely manner.</p>		<p>sighted in files reviewed. Progress notes are signed each duty by care staff and weekly by the RN in the rest home and each duty in the hospital. Evidence is seen of the family involvement in the care reviews. In files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. The residents and family members interviewed report that they are given the opportunity to be involved in all aspects of care and reviews.</p> <p>The clinical staff interviewed have knowledge of the care plan documentation requirements.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The policy related to exit, transfer or transition states that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary. The family will be notified of the upcoming appointment and will be invited to attend and assist.</p> <p>In residents' files reviewed required referrals to other health services. Information relating to the referral process is sighted in residents' files.</p> <p>Residents are given a choice of GP when they are admitted. Most residents use the GP contracted to Matamata Country Lodge. If the need for other services are indicated or requested, the GP or NM sends a referral to seek specialist assistance from the WDHB. The resident and the family are kept informed of the referral process.</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>	<p>FA</p>	<p>Chemicals are stored securely in the rest home, hospital and assisted living areas of the service. Chemicals were clearly labelled and safety data sheets were available. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff confirmed they can access PPE at any time and were observed wearing PPE appropriately. Staff demonstrated knowledge of handling waste and chemicals.</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>	<p>FA</p>	<p>There is a current building warrant of fitness. There are annual safety inspection certificates for the lifts. Maintenance is undertaken by both internal maintenance and external contractors as required. Electrical safety testing and medical equipment calibration occurs to comply with standards. All electrical equipment sighted had an approved testing tag.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, and there are hand rails in corridors. There are stairs and lifts to the upper floor in the assisted living complex. The service identifies planned monthly maintenance and uses hazard</p>

		identification forms for areas that require ongoing maintenance. Regular environmental audits sighted identified that the service actively strives to maintain a safe environment for staff and residents. There are external areas off the lounge and dining areas and some resident rooms. Residents and family/whānau members confirmed the environment was suitable to meet their needs
<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	There are ensuite facilities and adequate centrally located toilet/shower facilities for residents with separate staff and visitor facilities. The ALC area, hospital and some rest home areas have ensuite facilities. In the rest home section, there are shared toileting facilities that are conveniently located to the rooms. Hot water temperatures are monitored and documentation identifies that they remained within safe levels.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. There has been one apartment room in the assisted living complex that has been converted to two single rooms. These rooms sighted are of appropriate size and location for rest home level of care. Rooms have appropriate areas for residents to place personal belongings. Residents and family members confirmed they are satisfied with their bedrooms.
<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	Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Dining and lounge areas are separate rooms in the rest home and ALC areas. The hospital has an open planned space for lounge and dining, with this area separated by the layout of furniture. The areas are appropriately furnished to meet residents' needs. Activities are undertaken in the lounge and dining areas. Residents and family/whānau expressed satisfaction with the environment.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry</p>	FA	The service has standing operating procedures in place for cleaning. There is a dedicated storage area for cleaning equipment and chemicals in all wings of the service. The external chemical supplier provides a monthly report on the effectiveness of the cleaning and laundry equipment and chemical usage.

<p>services appropriate to the setting in which the service is being provided.</p>		<p>All laundry, including residents' personal laundry, is undertaken onsite by the laundry staff. There are laundry areas in the ALC/rest home and hospital sections of the service. Residents and family/whānau confirmed they are satisfied with the laundry services provided.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management policies and procedures guide staff actions in the event of an emergency. The emergency plans take into account emergency systems, such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. There is access to emergency supplies and equipment, including food and water. The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved evacuation scheme. Emergency education and training for staff includes six monthly trial evacuations. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking. The service has a generator that can operate the filtration system for the emergency water supply. Appropriate security systems are in place. Staff and residents confirmed they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviewed confirmed call bells were answered in an acceptable timeframe. Monthly inspection was recorded for the call bell system.</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>	<p>FA</p>	<p>The facility is centrally heated. Each resident's room and living area has adequate ventilation and natural light through external windows and doors. The residents report satisfaction with the heating and ventilation.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The role of the infection control coordinator and the responsibilities is identified in the infection control manual. The IPCC (Infection Prevention Control Coordinator) is responsible for facilitating the infection prevention and control programme. The staff and managers interviewed confirm timely ongoing communication is occurring when residents are suspected or confirmed as having an infection. This includes shift handovers and discussion at monthly staff meetings.</p> <p>An annual review of progress towards achieving the infection prevention and control objectives has been undertaken by the IPCC in February 2015. All objectives have been met and there is a process</p>

		for any areas that may to be actioned for improvement.
<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 IPCC confirmed being responsible for facilitating infection prevention and control activities. The IPCC has attended relevant education on infection prevention and control. The IPCC advises she liaises with the GP if there are any concerns about a resident with a known or suspected infection.</p> <p>The IPCC is responsible for gaining infection control, infectious disease and microbiological advice and support, where this is not available within the organisation. In the event of an outbreak advice will be sought from GP, gerontology nurse specialist at the DHB or Laboratory services.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual contains the policies and procedures required to meet this standard.</p> <p>A copy of the infection prevention and control policies are available for staff to refer to as and when required and this was sighted. Staff interviewed confirmed access to policies on infection prevention and control. Staff reported if they had any concerns they would contact the NM who is on call when not on site. The GP confirmed in interview that he is contacted by staff in a timely manner when the needs of the resident have changed.</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 provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. In addition newsletters issued by an external infection control company and WDHB include infection prevention and control topics. As an example, during audit the newsletter received was on urinary tract infections. This information was disseminated to staff.</p> <p>Residents and family are provided with advice on infection prevention and control activities via residents' meetings. The residents' meeting minutes included discussion on the importance of hand hygiene.</p>
Standard 3.5: Surveillance	FA	The infection control programme includes documented definitions of infections. The surveillance

<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>		<p>method is also defined and suspected infections are reported on a template form. There is a monthly analysis of infections.</p> <p>Surveillance for residents with infections is occurring. Staff interviewed reported they are responsible for advising the RN if they are concerned a resident has an infection. The staff on interview were able to identify the common signs and symptoms of infections.</p> <p>A recent outbreak was managed as per policy requirements. Evidence was seen of the outbreak report which included isolation processes implemented, notifications, numbers and any areas for improvement which may be implemented.</p> <p>A review of the applicable residents' notes verified short term care plans were developed as required for residents with infections and that infections are being appropriately reported.</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 policies sighted meet the Standard's requirements. Strategies for managing challenging behaviours and falls minimisation strategies are implemented to minimise the use of restraints. The restraint register records there were six residents requiring restraint (bed rails and parachute lap harness) and one residents with enabler use (bed rails). Where enablers were used these were voluntary and the least restrictive option for the safety and comfort of the residents. There is a record of staff training on restraint minimisation and the care staff demonstrated knowledge on restraint and enabler use.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The approved restraints and enablers at the service are the use of bed rails and a parachute lap harness. The restraint coordinator reports that the service has reduced the use of the types and number of restraints used.</p> <p>There is a restraint approval committee that meets at least six monthly. The restraint coordinator and restraint committee have approved all restraint use. The GP reviews the restraint committee meeting minutes. Consent from family/whanau and a RN is required before restraint is approved. The consent form and approval process was sighted in the files reviewed of residents with restraint use.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>The service has a restraint assessment form that included the factors of this standard. The restraint coordinator reported that restraint is only put in place following an appropriate review of the risks and benefits of restraint or enabler use. The assessment process was sighted in the residents' files. Care</p>

undertaken, where indicated, in relation to use of restraint.		staff demonstrated, understood and implemented alternatives to restraint, such as low beds and sensor mats, whenever possible.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint coordinator reported that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is monitored according to risk. Frequent falls from bed by individual residents will often generate commencement of reviewing the need for bed rails. The restraint documented all restraint and enablers in use. The restraint register records the type of restraint, when approved, review dates and if the restraint is still recommended for use. The register records that the service has reduced the numbers of residents with restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The evaluation process included all the points required within this standard. The restraint coordinator reported that all restraint and enabler use is evaluated at least six monthly as part of the resident review process. Within two days of when restraint is initially implemented, there has been a review and evaluation of its appropriateness and effectiveness. The evaluation process was sighted in the files of residents with restraint use. Restraint reviews are discussed at the restraint committee meetings. The resident and family/whanau consultation and evaluation was evidenced in the files of the residents with restraint use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The six monthly restraint approval committee monitors and reviews the restraint and enabler use for the service. As part of the internal auditing system, an annual review of the restraint processes is conducted. Restraint use is closely linked to the falls reduction programme. All restraints are used for the safety and comfort of the resident. The service is further reviewing alternative options, such as an antiroll mattress to minimise the use of bedrails.

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.

No data to display

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.