Kaiapoi Lodge Residential Care 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 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:	Kaiapoi Lodge Residential Care Limited
Premises audited:	Kaiapoi Lodge Residential Care Ltd
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 July 2015 End date: 2 July 2015

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: 49

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

Kaiapoi Lodge provides rest home and hospital level care for up to 49 residents. On the day of the audit there were 49 residents. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, and staff.

The facility manager is a registered nurse who is appropriately qualified and experienced. He is supported by a clinical manager/registered nurse. There are quality systems and processes being implemented. The service reflects a culture of continuous quality improvement.

Improvements are required around documenting times and designations in the residents' progress notes, clinical assessments, medication management, and dry goods food storage.

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 an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumer rights is provided to residents and families during the admission process. The residents' cultural, spiritual and individual values and beliefs are assessed on admission and are being met by the service. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. Business goals are documented for the service with evidence of regular reviews. A system is in place for the collation, trending, analyses and evaluation of quality and risk data that is regularly collected. Preventative measures are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. On-going education and training is in place for staff.

Registered nursing cover is provided 24 hours a day, seven days a week. The integrated residents' files are appropriate to the service type.

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

Each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management have current medication competencies.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

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.

All building and plant comply with legislation. There is a current building warrant of fitness in place. Appropriate systems, including preventative and reactive maintenance are in place to ensure the residents' internal and external environment and equipment are safe and facilities are fit for their purpose. Residents and family described the environment as meeting their needs. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Emergency systems are in place in the event of a fire or external disaster.

There is protective equipment and clothing and staff were observed to use them. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems include appropriate monitoring systems to evaluate the effectiveness of these services.

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.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. The service had four residents in the hospital assessed as using a restraint and one resident in the hospital using an enabler. A register is maintained by the restraint coordinator. Residents using restraints are reviewed three-monthly at a minimum. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

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 control programme is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator/registered nurse is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

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	46	0	4	0	0	0
Criteria	0	96	0	5	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	There is an implemented policy on residents' rights to guide practice. Discussions with five caregivers (two caregivers who work in the rest home and three caregivers who work in the hospital) confirmed their understanding of the Code of Health and Disability Consumers' Rights (the Code). Interviews with eight residents (four hospital level and four rest home level) and seven relatives (five with family at rest home level of care and two with family at hospital level of care) confirmed the service is provided in line with the Code. Staff training on the Code begins during their orientation to the service and continues regularly as an inservice topic.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreement. The clinical manager and the facility manager reported informed consent was discussed and recorded at the time the resident is admitted to the facility. Staff interviewed demonstrated a good understanding of informed consent processes. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained on residents' files, where residents have named EPOAs. Residents and family interviewed confirmed they have been made aware of and understand the principles of informed

		consent, and confirmed informed consent information has been provided to them and their choices and decisions are acted on. Advanced directive were sighted in the residents' files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights and HDC Advocacy Services pamphlets on entry. An HDC Advocacy poster is displayed adjacent to where the complaints forms are held. Interviews with the managers and staff described how residents are informed about advocacy and support. Residents and families identified that the service involves them in decision-making. They confirmed that they are aware of their right to access advocacy support.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	All families interviewed stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit. The activities programme encourages links with the community. Activities include opportunities to attend events outside of the facility including shopping and visits to the residents' homes. Two-weekly intergenerational visits to a local kindergarten include 15 rest home level residents. Interviews with the rest home level residents confirmed that the activity staff help them access the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives during entry to the service. A record of all complaints is maintained by the facility manager using a complaints' register. Two complaints received in 2015 (year to date) were reviewed and reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Both complaints have been signed off by the facility manager as resolved. Complaints received are discussed in the quality meetings and in the staff meetings, evidenced in meeting minutes. Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaints forms and a suggestions box are located in a visible location at the entrance to the facility. Residents and families confirmed that they are comfortable speaking with the managers if they have a concern and that concerns are dealt with promptly.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code posters and brochures are displayed in public areas of the facility. The information pack given to prospective and admitted residents and their families include pamphlets on the Code and the Health and Disability Advocacy Service. The admission agreement contains information relating to consumer rights. Interviews with residents and family confirmed that consumer rights were explained during the admission process. They also confirmed that residents' rights are being upheld by the service. Regular residents' meetings provide opportunities to discuss aspects of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There is an implemented policy supporting the privacy of residents. Residents' rooms are single, private rooms with only one double room that is occupied by a married couple. Consent processes and visual privacy are upheld. Privacy signage and locks are on public toilet and shower doors. Discussions with residents and relatives confirmed their privacy is respected with examples provided. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Spiritual, religious, and cultural information that is relevant is gathered during the entry process and is sufficient to support responding to the individual needs of the residents. A satisfaction survey is carried out annually to gain feedback. Eight residents' files reviewed (four rest home level and four hospital level) confirmed that cultural and/or spiritual values and individual preferences are identified. Residents are supported and encouraged to maintain their independence, confirmed in interviews with staff. A physiotherapist is on-site as needed. The abuse/neglect policy includes definitions and the process for reporting to ensure resident safety. Abuse and neglect training is included in the staff orientation programme and as a regular inservice topic. Discussions with the managers and staff identified that there have been no reported incidents of abuse or neglect. Staff are trained to report any concerns.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges	FA	There is a Maori health care plan in place. Kaiapoi Lodge employs the services of a minister as a cultural advisor. This individual is a member of Ngai Tahu, has strong ties with the Tuahiwi Marae, and is known to the facility's Maori residents and whanau. His role includes reviewing documentation, assessing the suitability of the service, welcoming new persons to the service and acting as a cultural support person. He provided two (separate) staff in-services over the

their individual and cultural, values and beliefs.		past year on death and dying (for Maori). There are two residents at a hospital level of care who identify as Maori. One whanau interviewed reported that the resident's cultural needs are being met by the service. Discussions with staff confirmed their understanding of the cultural needs of residents, including the importance of involving whanau in the delivery of care.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	A culturally appropriate service is provided, which includes assessing residents' needs on admission. Even if family cannot be present during the admission process, the initial assessment on admission is reviewed with family. Individual values and beliefs are identified through the assessment and care planning process. Family are invited to be part of the care planning process, providing the opportunity to be involved in all aspects of care delivery. Staff and family are available as interpreters if needed. There were no residents at the facility where English is their second language. Families and residents interviewed expressed their satisfaction with the services that the residents are receiving.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Policies outline the service's responsibilities to ensure residents are not subjected to discrimination, coercion, harassment, and sexual or other exploitation. Education and training is provided to staff, beginning during their orientation to the service, including professional boundaries, code of conduct, abuse and neglect and residents' rights. Professional boundaries are assessed in staff performance appraisals. Residents and families interviewed confirmed that they do not feel they are discriminated against.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. The managers and staff are committed to continuous quality improvement (CQI) processes. Registered nursing staff are available seven days a week, 24 hours a day. Residents identified as stable are reviewed by the general practitioner (GP) every three months, with more frequent visits scheduled for those residents whose condition is not deemed stable. The service receives support from the Canterbury District Health Board (CDHB) and local community hospice services. Examples include visits from the CDHB (mental health team, infection control specialists, stroke rehabilitation team, occupational and speech therapists, and nurse specialists) and palliative care nursing visits by the community hospice. A physiotherapist is available on an as needed basis.

		There is a regular in-service education and training programme for staff that exceeds contractual requirements. Staff competency assessments are completed for medication, hand hygiene, wound care, restraint use and manual handling. All caregiver staff receive supervision by registered nurses. The service has maintained strong links with the local community and encourages their active residents to remain independent with examples provided. Residents interviewed spoke positively about the care and support provided. Care staff interviewed have a sound understanding of the principles of aged care and state that they are supported with their on-going professional development. Registered nurses have paid study time off. If registered nurses can demonstrate relevance of training to the facility, consideration is also given to funding of the course.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies and procedures relating to accident/incidents and open disclosure identify staff responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whanau is recorded on the accident/incident form and in the family communication sheet that is held in each resident's file. Fifteen accident/incident forms that were reviewed across the rest home and hospital identified family are kept informed. Family interviewed stated that they are kept informed when their family member's health status changes. Contact details of available interpreters are available. Staff and family assist as they are able. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Kaiapoi Lodge has been owned and operated by the CEO for the past 25 years. The service has 49 beds. At the time of the audit the facility was fully occupied with 19 residents receiving rest home level care and 30 residents receiving hospital level care. Kaiapoi Lodge has a current (2015) business plan and a quality and risk management programme that describes annual goals and objectives. Goals and objectives are regularly reviewed by the management team (CEO, facility manager, clinical manager). The facility manager is a registered nurse with a current practising certificate who has worked

		full time at the facility for the past eight years. He and the CEO are supported by a clinical manager who is a registered nurse with a postgraduate diploma in gerontology who has worked at the facility for 20 years. The facility manager has maintained over eight hours annually of professional development activities related to managing an aged care service. He regularly attends Aged Care Association meetings and meetings with the CDHB. He has also completed his InterRAI training.
Standard 1.2.2: Service Management 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.	FA	During the temporary absence of the facility manager, the clinical manager/registered nurse covers the facility manager's role.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A 2015 quality and risk management programme is in place. This programme is guided by an external consultant who is responsible for policies and procedures and document control. Interviews with the CEO, facility manager, clinical manager and staff (five caregivers, three registered nurses, one activities coordinator, one cleaner, one laundry staff, one cook) reflect an understanding of the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Data collected (e.g. falls, medication errors, wounds, skin tears, challenging behaviours) are collated, analysed, evaluated and used for service improvements with evidence of preventative measures identified, implemented and evaluated to determine their overall effectiveness and outcomes achieved. Findings are discussed in details with staff, evidenced in the meeting minutes. Internal audits are completed as documented in the audit schedule (sighted for 2014 and 2015). Areas of non-compliance include discussing finding in staff meetings and in the quality meetings, documenting and implementing corrective actions and sign-off by the facility manager when

		completed. Corrective actions are instigated within seven days of the completion of the internal audit. Falls prevention strategies include identifying all residents who require mobility equipment and ensuring supervision is in place if residents forget their equipment, investigating falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented, and the use of sensor mats. A health and safety programme is in place. A health and safety representative/RN has been identified. Health and safety goals are documented for the service. Hazard identification forms and a hazard register are in place. Staff orientation includes health and safety. Health and safety internal audits are regularly conducted.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Data collected on incident and accident forms are linked to the quality management system. The managers are aware of their responsibility to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies address recruitment, orientation and staff training and development. Eight staff files that were randomly selected for review (four caregivers, two registered nurses, one clinical manager, one cook) included evidence of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. Current annual practising certificates were sighted for the registered health professionals. There is an annual education and training schedule that exceeds eight hours per annum. Mandatory training is well-attended by staff. Aged Care Education (ACE) is undertaken by the caregivers with one (RN) assessor on-site. Education and training for registered nursing (RN) staff is supported by the CDHB and nurse practitioners/specialists. Four out of six permanent RN's have completed their InterRAI training, which is adequate to meet contractual

		requirements. Competency assessments are in place for medication management, restraint minimisation, manual handling and hand washing. Two yearly chemical safety training is in place.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing levels meet contractual requirements. The facility manager and clinical manager are registered nurses who are available during weekdays. Adequate on-site RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. Interviews with the residents and relatives confirmed staffing overall was satisfactory.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	The resident files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is developed in this time. The RNs are currently in the process of completing InterRAI assessments for the residents. All new admissions have an InterRAI assessment completed. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in secure metal filing cabinets. Archived records are stored securely in a locked room on the premises. Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant caregiver or registered nurse. Missing is consistent evidence of the time of entry and the staff member's designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry and assessment processes are recorded. Information specific to this service is recorded and communicated to residents, family, relevant agencies and staff. This facility operates 24 hours a day, seven days a week. The facility information pack is available for residents and their family and contains all relevant information. Residents' admission agreements evidenced resident and/or family and facility representative sign off. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is appropriate communication between families and other providers that demonstrate transition, exit, discharge or transfer plans are communicated when required. Transition, exit, discharge, or transfer form/letters/plan are located in residents' files, where this is required.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	Prescribed medications are delivered to the facility and checked on entry. The medication areas, including controlled drug storage areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug registers are maintained and evidence weekly checks and six monthly physical stock takes. The fridge temperatures are conducted and recorded. All staff authorised to administer medicines have current competencies. Medication rounds were observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are maintained, as are staff specimen signatures. Staff education in medicine management was conducted. Missing was evidence of compliance around medication prescribing and evidence that residents who self-administer medications follow policy.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	The food service policies and procedures are appropriate to the service setting with seasonal menu reviewed by a dietitian. In interview, the cook confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements are identified and documented. Copies of the residents' dietary profiles are kept in the kitchen. The kitchen staff are informed if resident's dietary requirements changed, confirmed at interview with the cook and the clinical manager. Staff have completed safe food handling training. The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service. The food temperatures are recorded as are the fridge, chiller and freezer temperatures. Missing was evidence that decanted dry goods were dated.
Standard 1.3.2: Declining Referral/Entry	FA	The scope of the service is identified and communicated to all concerned. Management stated that a process to inform residents and family, in an appropriate manner, of the reasons why the

To Services 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.		service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available. The resident would be referred back to the referring service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The residents' files reviewed identified that the needs, outcomes and goals were identified via the assessment process and recorded (refer to 1.3.3.3). The facility has processes in place to seek information from a range of sources, for example, family, GP, specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The residents' files evidenced residents' discharge/transfer information from district health board (DHB) (where required) were available. The facility has appropriate resources and equipment, confirmed at staff interviews. In interviews, the RNs and clinical manager confirmed that assessments were conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The care plans reviewed were individualised and up to date. The residents' files were in hard copy, with records such as, wound assessments and wound care plans; falls assessments; pressure area assessments; pain assessments; weight monitoring and observation. In the files reviewed, the care plan interventions reflected the assessments and the level of care required. Short term care plans are developed, when required and signed off by the RN when problems are resolved. In interviews, staff reported they received adequate information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented, sighted in current GP progress reports.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet	FA	The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records were current. In interviews, residents and family confirmed their and their relatives' current care and treatments met their needs. Family communications are recorded in the residents' files. Nursing progress notes and observations charts are being maintained. In interviews staff confirmed they were

their assessed needs and desired outcomes.		familiar with the current interventions of the resident they were allocated.
Standard 1.3.7: Planned Activities 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.	FA	The activities coordinator works fulltime and is able to manage the planning, implementation and review of the programme as well as activities assessments and care plans within specified timeframes. Activities attendances are monitored and reviewed by the activities coordinator. Residents' feedback is obtained from residents at residents' meetings and satisfaction surveys. In interview, the activities coordinator confirmed the activities programme meets the needs of the service group and the service had appropriate equipment. The activities coordinators plans, implements and evaluates the activities programmes. Regular exercises and outings are provided for those residents able to partake. Interviews with residents, family and staff confirmed the activities programme included input from external agencies and supported ordinary unplanned/spontaneous activities including festive occasions and celebrations. There were activities assessments, care plans and care plan evaluations in residents' files reviewed.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly. There is evidence of multidisciplinary input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations. The residents' progress notes record the care provided to residents. When resident's progress is different than expected, the RN or the clinical manager contact the GP, as required. Short term care plans are utilised as required. The family are notified of any changes in resident's condition, confirmed at family interviews and evidenced in the progress notes reviewed. There is recorded evidence of additional input from professionals, specialists or multi-disciplinary sources, if this was required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. Completed referral forms/letters were sighted in some files reviewed. This included referrals to DHB specialists. Family involvement is recorded in the residents' progress notes. An effective multi-disciplinary team approach is maintained and progress notes detail relevant processes are implemented.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff interviewed reported they had received training and education on safe and appropriate handling of waste and hazardous substances. Hazardous substances are correctly labelled and sluice facility is provided for disposal of waste. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled are provided and used by staff. Material safety data sheets are available and accessible for staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The owner/CEO is responsible for the maintenance at the facility. There is a preventative and reactive maintenance programme in place. External contractors are used for plumbing, electrical and other specialist areas. There is a calibration programme for medical equipment and electrical safety checks. Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment. A current building warrant of fitness is displayed and expires on 30 June 2016. There are secure safety rails and these are appropriately located. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. External areas are available for residents and these are maintained and appropriate to the resident groups. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	The service has an adequate number of communal showers, toilets and hand basins for residents. A separate toilet facility is provided for staff and visitors. Toilets and showers are of an appropriate design and number to meet the needs of the residents. Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. Hot water temperatures are monitored and maintained at a safe temperature.
Standard 1.4.4: Personal Space/Bed	FA	All bedrooms provide single accommodation and are personalised with resident's possessions.

Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		An adequate personal space is provided in bedrooms to allow residents and staff to move around safely.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Adequate access is provided to the lounges, sitting areas and dining rooms. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry policy and procedures are available. All linen is washed on site and there is adequate dirty/clean flow in the laundry. The laundry person was interviewed and described the management of laundry processes and services. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. In interview the cleaner described the cleaning processes and knowledge of the use of chemicals. Safe and secure storage of chemicals is available and staff have appropriate and adequate access to these areas. Residents and family interviewed stated they were satisfied with the cleaning and laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate training, information, and equipment for responding to emergencies are provided. Fire evacuations are held six monthly. There is a minimum of one registered nurse available 24 hours a day, seven days a week with a current first aid certificate. Civil defence and emergency policies and procedures are in place. Civil defence kits are readily accessible. An up to date register of all residents' details are held. There is an approved evacuation plan. The facility is well prepared for civil emergencies and has emergency lighting. A store of emergency water is kept. There is a gas BBQ for alternative cooking. Emergency food supplies are sufficient for three days. Extra blankets are available. Hoists have battery packs and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence

		products and personal protective equipment are stored at the facility. The electronic call bell system is available in all areas. Residents were observed to have easy access to the call bells. Residents interviewed stated their bells were answered in a timely manner.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents and family interviewed confirmed the facility is maintained at an appropriate temperature. Residents' rooms are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management 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.	FA	The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The facility manager (RN) is the designated infection control coordinator (ICC). There is an implemented infection control programme that is linked into the quality management system. Infection control matters are integrated with the facility's meetings.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICC has access to an infection control nurse specialists, public health, GP's and microbiologists. Interview with the ICC confirmed attendance at monthly IC meetings at DHB.
Standard 3.3: Policies and procedures 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	FA	There are current infection control policies that reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practise. The infection control policies link to other documentation and cross reference where appropriate.

policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICC attends monthly meetings at the DHB and these provide up to date information on infection control matters. The ICC is responsible for coordinating/providing education and training to staff at the facility. The ICC has appropriate knowledge and education for the role. The induction package includes specific training around hand washing and standard precautions. Training on infection control has been provided. Resident education is expected to occur as part of providing daily cares.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Systems in place are appropriate to the size and complexity of the facility. The ICC uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. There were no outbreaks at the facility since last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had one hospital level resident using bedrails as an enabler. Residents using an enabler undergo an assessment process similar to those residents being assessed for a restraint.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (facility manager/RN) and for staff are documented and understood. The restraint approval form identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. On-going consultation with the resident and family/whanau are evident. Two hospital-level residents' files were reviewed where restraint was in use. Completed assessments considered those listed in in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints include bed rails, lap belts, pelvic belts and thigh belts. The restraint coordinator (facility manager) is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents' care plans. Internal audits conducted measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two residents' files where restraint was in use. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of two files of residents using restraints identified that evaluations are up-to-date.

Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraints are discussed and reviewed at the annual restraint meetings, attended by the restraint coordinator/facility manager, clinical manager and CEO. Meeting minutes include (but are not limited to) a review of the restraint and challenging behaviour education and training programme for staff and review of the facility's restraint policies and procedures.

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)
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Residents’ files are legible and include the name of the service provider. Residents’ progress notes occasionally lack the time of entry and staff designation.	There is inconsistent recording of time of entry and staff designation in the progress notes.	Ensure residents’ progress notes consistently document the time of entry and staff designation. 90 days

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medicine charts evidenced residents' photo identification, recorded allergies, legibility and three monthly medicine reviews. The residents' medicine charts recorded all medications a resident was taking (including name, dose, frequency and route to be given). Twenty medication charts were reviewed: ten rest home and ten hospital. Shortfalls were identified around medication documentation.	(i) Three of ten rest home medication charts evidenced: as required medications (PRN) did not record indication of use (ii) two of ten medication charts did not have discontinued medications signed and/or dated. (iii) Five of ten hospital medication charts evidenced: PRN medications did not have indication of use: (iv) one of ten evidenced discontinued medication was not signed and (v) three of ten medication charts were block signed by the GP.	Provide evidence medication prescribing complies with legislation, protocols and guidelines. 30 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There is a current policy on self-administration of medicines. On days of audit there were two residents who self-administer medicines (inhalers). The self-administration of medicines had not been conducted according to policy and guidelines.	Residents who self-administer medicines do not follow the policy and guidelines for self-administration. (Assessments of the resident being competent to self-administer medicines and recording administration)	Provide evidence residents' who self-administer medicines do so according to policy. 30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Kitchen was observed to be clean and tidy. Interview with the cook confirmed cleaning schedules are followed. Large selection of dry foods were observed to be decanted. Food stored in the refrigerator is dated.	Decanted foods are not dated.	Provide evidence the foods that are decanted are dated. 180 days
Criterion 1.3.3.3 Each stage of service	PA Low	Eight residents' files reviewed included four files of rest home residents and four hospital residents. Eight long term care	Four of four rest home residents' files evidenced the assessments were not consistently	Provide evidence rest home

provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		plans had been completed within three weeks and evaluated six monthly. Timeframes of assessments are not consistently completed in the rest home within the required timeframes, as stated in policy and ARC contract.	completed within the required timeframes.	residents' assessments are conducted within the required timeframes. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.