

Karaka Court Limited - Woodlands of Palmerston North

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:	Karaka Court Limited
Premises audited:	Woodlands Of Palmerston North
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 3 August 2015 End date: 4 August 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:	27

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Woodlands of Palmerston North provide rest home and dementia level care for up to 42 residents. On the day of the audit there were 27 residents and two private boarders. The service is managed by a manager and a clinical leader. 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 manager is appropriately qualified and experienced. She has been in her role for six years. She is supported by a clinical leader/registered nurse.

Improvements are required around admission agreements, professional development for the manager, management of policies and procedures, medication management, the activities programme and the call bell system.

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.		Some standards applicable to this service partially attained and of low risk.
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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 consumers' rights is provided to residents and families during the admission process. Residents' cultural, spiritual and individual values and beliefs are assessed on admission. Evidence-based practice is evident, promoting and encouraging good practice. 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.
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Woodlands Rest Home has a current business plan that outlines goals and objectives for the year. The quality and risk management programmes include an internal audit programme, monitoring adverse events and a health and safety process that includes hazard management. Quality information is posted in the staff room and is discussed during staff meetings. Residents and family are provided the opportunity to feedback on issues at resident meetings and via annual satisfaction surveys.

Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. An education and training programme is in place for staff. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet residents' needs. Registered nursing cover is provided five days a week. A registered nurse is on call when not available onsite. There are adequate numbers of staff on duty to ensure residents are safe.

The 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 medium or high risk and/or unattained and of low risk.
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The service has a well-developed assessment process and resident's needs are assessed prior to entry. Assessments, care plans and evaluations are completed by the registered nurse. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services.

The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The service medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food that was 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.		Some standards applicable to this service partially attained and of low risk.
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Chemical safety is maintained. There is adequate equipment provided to ensure the needs of residents are met and suitable equipment to provide care is available. The building holds a current warrant of fitness. A maintenance prevention programme is implemented. Electrical equipment is checked annually. There are a number of communal lounges and dining areas. There are documented laundry services policies/procedures. There is a plentiful supply of protective equipment, gloves, and aprons. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan. The facility has civil defence kits and emergency management plans.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

There is a restraint policy that includes comprehensive restraint procedures. There are currently no residents requiring enablers or restraints. Staff are trained in restraint minimisation and 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.

Infection control management systems are in place to minimise the risk of infection to residents, staff and visitors. The infection control programme is implemented, meets the needs of the service, and provides information and resources to inform staff and other health professionals. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and also as part of their on-going education programme. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	39	0	4	2	0	0
Criteria	0	87	0	4	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Consumers' Rights (the Code) poster is displayed in English and in Māori. Policy relating to the Code is implemented. Staff receive training about the Code during their induction to the service, which continues through on-going education and training. One registered nurse (RN) and four caregivers (two from the rest home and two from the secure dementia unit) were able to describe how the Code is implemented in their everyday delivery of care.</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>	PA Low	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately. There is evidence of discussion with family when the GP completes a clinically indicated not for resuscitation order. Care staff interviewed confirmed verbal consent is obtained when delivering care. Discussions with family members identified that the service actively involves them in decisions that affect their relative's lives. Signed consents were present in all seven residents' files reviewed. Signed admission agreements were not evidenced in all the residents' files selected for review.</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>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. This information is also available at reception. Interviews with residents and family confirmed their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.</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>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. Links to the community are in place. The service encourages the residents to maintain their relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do.</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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. They confirmed that the manager is approachable and operates an "open door" policy, which was observed during the audit. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register is maintained. There has been one complaint received by the DHB in July 2015. There was evidence of this complaint being acknowledged with a formal investigation underway. Other than this complaint, no complaints have been lodged since 2012.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information pack that is provided to new residents and their family. Information is also available at the entrance to the facility. The manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the residents' meetings. All six rest home level residents and three family (two with family members in the dementia unit and one with a family member in the rest home) interviewed, report the residents' rights are being upheld by the service.</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 service ensures that the residents' right to privacy and dignity are recognised and respected at all times. The residents' personal belongings are used to decorate their rooms. All rooms were single occupancy at the time of the audit. The caregivers interviewed report that they maintain residents' privacy. They report that they facilitate the residents' independence by encouraging them to be as active as possible.</p> <p>All of the residents and families interviewed report that their family member's privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which is linked to their training on the Code and the adverse event reporting process.</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 service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Staff encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were no Māori residents living at the facility during the audit.</p> <p>Māori links have been established with a local Māori advocate. Staff receive education on cultural awareness during their induction to the service, which continues as a regular education and training topic. All care staff interviewed could describe cultural needs identified by Māori and are aware of the importance of whānau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. Beliefs and values are discussed and incorporated into the care plan, sighted in all seven care plans reviewed (three dementia level and four rest home level). All residents and family interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs and cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Professional boundaries are discussed with each new employee and are linked to the employment agreement (sighted in all seven staff files reviewed). Professional boundaries are defined in job descriptions, which are signed by staff. Interviews with staff (four caregivers, one registered nurse, one cook, one cleaner, one diversional therapist) confirmed their understanding of professional boundaries. Professional boundaries are reconfirmed through</p>

		education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. A registered nurse is available on site 40 hours per week and is on call when not at the premises. Residents are reviewed by the general practitioner (GP) every three months at a minimum.</p> <p>The service receives support from the MidCentral Health, which includes visits from a range of specialty services (e.g. psycho-geriatrician, mental health services). Physiotherapy services are available as needed. There is a monthly in-service education and training programme for staff. Residents who require podiatry services are taken to a podiatrist at no extra charge. A hairdresser is available as required. A van is available for regular outings. Community outings include regular visits to local cafes, parks and shopping.</p> <p>All residents and family interviewed expressed their satisfaction with the care delivered. The GP was unavailable for interview.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There is a policy to guide staff on the process around open disclosure. Family are informed of an accident/incident unless the resident has consented otherwise. This was confirmed in the sample of accident/incident forms reviewed. Interview with the clinical leader/registered nurse (RN) confirmed family are notified following changes in health status. Family interviewed stated they were kept informed.</p> <p>Residents' meetings provide a forum for residents to discuss issues or concerns on every aspect of the service. Access to interpreter services are available if needed although have not been required.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and can be read to residents who are visually impaired.</p>
Standard 1.2.1: Governance The governing body of the organisation	PA Low	Woodlands of Palmerston North provide care for up to 42 residents across two service levels (rest home and dementia). On the day of audit there were 17 rest home residents and 10

<p>ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>residents in the dementia unit. There were two boarders living independently at the facility.</p> <p>The two directors own two aged care facilities - one in Fielding and Woodlands of Palmerston North. There is a 2015 business plan that covers both the Palmerston North and Fielding facilities and outlines objectives for the year. Woodlands of Palmerston North has identified annual goals that link to the business plan.</p> <p>The service is managed by an experienced (non-clinical) manager who has been in the post for six years. She reports to one of the directors monthly and is supported by a clinical leader (RN) who works full time Monday – Friday. The clinical leader has been in her role for seven months. The manager has not maintained at least eight hours annually of professional development activities related to managing a rest home.</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>A director covers in the absence of the manager. The clinical leader/RN is responsible for all clinical operations. An RN from the other aged care facility in Fielding, covers on-site in her absence.</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>PA Low</p>	<p>A 2015 quality and risk management plan is in place with goals listed. Policies and procedures have been developed with assistance provided by an external quality consultant. Policies are currently in the process of being linked to InterRAI. The system for document control is in transition. Staff are made aware of any policy changes through regular meetings and by reading (and signing) information that is held in a reading file in the staff room.</p> <p>The monthly collating of quality and risk data includes monitoring accidents and incidents and infection rates. Internal audits monitor compliance. Areas identified for improvement are documented on an audit summary sheet. Quality improvement plans are raised for corrective actions and areas for improvement. These have been followed up, signed off when implemented and outcomes are reported in the monthly meetings. Meeting minutes are posted in the staff room. Staff who are unable to attend meetings are asked to sign that they have read the meeting minutes.</p> <p>Annual resident/relative and food satisfaction surveys have been completed and collated with results provided to staff and residents. This was last completed in July 2015 with a corrective action plan forthcoming. Results overall reflect that the residents are satisfied or very satisfied</p>

		<p>with the services received.</p> <p>Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats are available if needed and falls risk assessments are in place. A physiotherapist is available on an as-needed basis.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective actions to minimise, and debriefing. Twelve incident reports selected for review reflect immediate action(s) taken and document follow up action(s) taken by the clinical leader/RN.</p> <p>The service collects monthly data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Monthly meeting minutes evidence discussions of incidents and accidents. This information is posted in the staff room.</p> <p>Discussions with the management team confirmed their awareness of statutory requirements in relation to essential notification.</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>There are human resources policies to support recruitment practices. The clinical leader's current practising certificate was available for sighting. Seven staff files were reviewed (clinical leader, diversional therapist, cook, three caregivers and one cleaner) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an annual education plan that is being implemented. Eighteen of twenty-two caregivers are overseas trained RNs and are completing RN competency training via a tertiary institution. In-service training is also provided for staff. Medication competencies are completed annually for caregivers and the clinical leader. The clinical leader has completed her InterRAI training.</p> <p>There is a staff member with a current first aid certificate on every shift.</p> <p>There are 15 caregivers who work in the dementia unit; all have completed 'gerontology level 7'</p>

		as part of the RN competency training programme which includes dementia care. The activities coordinator is a trained diversional therapist.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. A full time clinical leader/RN and the manager (non-clinical) are on site Monday to Friday. The clinical leader is on-call 24/7 when not on-site. Care giving staff are responsible for laundry. Cleaning staff work five days a week, four hours a day. A diversional therapist provides activities on a full-time basis Monday – Friday.</p> <p>Staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family interviewed advised that they felt there is sufficient staffing.</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>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access and are stored securely. Residents' files demonstrate service integration. Entries are legible, dated and signed by the relevant caregiver or RN, including time and designation.</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>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical leader screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical leader. The admission agreement form in use aligns with the requirements of the ARC contract and exclusions from the service are included in the admission agreement (link #1.1.10.4). The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. Records are kept with the residents' files. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.</p>
<p>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.</p>	<p>PA Moderate</p>	<p>The service uses robotic medication packs. Medications are checked on arrival by the clinical leader/RN and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely. Staff sign for the administration of medications on medication sheets held with the medicines. There were no expired medications in the medication cupboard or in the fridge. Controlled medication balances are checked weekly.</p> <p>RN or senior caregivers administer the medication in both areas. Annual medication competencies are completed. The clinical leader/RN advised there were no residents self-medicating on the day of audit.</p> <p>The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. The medication fridge is monitored daily (records sighted).</p> <p>Allergies were not evident in all 17 medication charts reviewed and not all medication orders record indication for use for 'as required' medication (PRN).</p>
<p>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.</p>	<p>FA</p>	<p>There is a large workable kitchen with two cooks rostered on. Both have completed food safety training. All residents have a nutritional and hydration care requirement developed on admission, which is reviewed at the six monthly review. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. The menu is designed and reviewed by a registered dietitian. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving.</p> <p>There is evidence that there are additional nutritious snacks available over 24 hours for dementia residents.</p> <p>The kitchen, kitchen equipment and kitchen staff are able to meet the needs of the residents.</p> <p>Equipment is available on an as needed requirement. Residents requiring extra assistance to eat and drink are assisted by caregivers and were observed during lunch.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents, should this occur and communicates this decision to residents/family/EPOA. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Comprehensive multidisciplinary assessments were completed in files sampled. All files reviewed had appropriate assessments on admission. Needs, outcomes and goals of residents were identified through the assessment process in the files sampled. Residents and family are consulted and agree to intervention outcomes. The clinical nurse leader has completed InterRAI training. There were no new residents who require the use of the assessment tool and no files reviewed evidenced that InterRAI has been commenced.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans sampled document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and demonstrate input from allied health.</p> <p>Short term care plans are in use for changes in health status.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation reviewed and interviews with staff, residents and relatives identified that the care that is being provided is consistent with the needs of residents. Two hourly monitoring charts and behaviour monitoring charts were sighted in files sampled.</p> <p>Residents' needs are assessed prior to admission. The service has two GPs that visit weekly or as required. During the tour of facility it was noted that all staff treated residents with respect and dignity.</p> <p>Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Wound assessment and wound management plans are in place for five residents with wounds. There were no pressure injuries. The registered nurse interviewed described the referral</p>

		process should they require assistance from a wound specialist.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>There is a qualified diversional therapist that provides activities in the rest home and the dementia unit. Two separate monthly activity programmes are developed, one for the rest home and one for the dementia unit.</p> <p>On the day of audit residents were observed being actively involved with a variety of activities in the rest home but this was not observed in the dementia unit. All residents are given a weekly plan. Residents have an activities/social profile assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, and family. Activities are age appropriate and are planned. There are several programmes running in the rest home that are meaningful and reflect ordinary patterns of life. There are also visits from community groups.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff through residents' meetings or following activities. There are regular outings. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by the clinical leader/RN six monthly or when changes to care occurred. Evaluations were documented and included progress to meeting goals. There was documented evidence of care plans being updated as required.</p> <p>There is at least a three monthly review by the GP.</p> <p>There are short-term care plans to focus on acute and short-term issues and these are reviewed and signed off when resolved.</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>Discussions with the clinical leader/RN identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The waste management policy and procedure outlines processes. Staff were observed wearing appropriate protective clothing. All chemicals sighted were appropriately stored in locked areas and fully labelled. There is an incident reporting system that is in use. A comprehensive emergency plan is available to staff which includes hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There was a current building warrant of fitness sighted, which expires on 4 April 2016. The facility is maintained in good order with regular maintenance. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person. Electrical appliances that are not permanently wired are checked annually by a contracted service.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required.</p> <p>The secure dementia has a separate lounge and dining area, which were both well-supervised on the day of audit. There is a secure outside/garden area.</p> <p>The external areas are well maintained and residents in both wings have access to gardens and indoor areas with ease.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rest home/dementia residents' share communal bathrooms and toilets. There were sufficient numbers of resident communal bathrooms and toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. The resident rooms are of sufficient size to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed reported that rooms have adequate room to allow cares to take place.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas are easily and safely accessible for residents. There are lounge areas and separate dining rooms, and small seating areas by the reception. The dementia unit has a lounge area and separate dining area. The main dining room was spacious, and located directly off the kitchen/server area. The furnishings and seating are appropriate for the resident group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The facility is cleaned by rostered cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done on site in the commercial laundry by caregivers. Residents and relatives interviewed were satisfied with the laundry service. The laundry and cleaning services are able to cater to the needs of rest home and dementia level residents.</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>	PA Low	<p>Emergency and disaster policies and procedures are in place. Fire evacuation drills take place every six months. The orientation programme and education and training programme includes fire and security training. Staff who are unable to attend complete competency questionnaires. Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan is in place.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and the availability of a gas BBQ. A back up battery for emergency lighting is in place.</p> <p>A call bell system is in place, suitable to meet the needs of the residents. The call bell system was not working in three toilet/shower areas during the audit. This was immediately fixed by a contractor during the audit. Residents report their call bells are answered in a timely manner.</p> <p>There is a minimum of one person rostered on each shift with a current first aid/CPR certificate. External lighting is adequate for safety and security. Doors are locked at dusk.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal rooms have an opening window to the outside. Electric heaters ensure warmth; all areas are warm and well ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Woodlands has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical leader/RN is the designated infection control nurse. There are monthly meetings and minutes available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control (IC) programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff through the staff meeting) have good external support from the local laboratory, infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>There are Woodlands infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control nurse and training and education of staff. The policies were developed by the contracted quality manager and have been reviewed and updated (link to finding 1.2.3.4).</p>
<p>Standard 3.4: Education</p>	FA	<p>The infection control policy states that the facility is committed to the on-going education of staff and residents. Formal infection control education for staff has occurred. The infection control</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>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.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Woodlands' infection control manual. Systems in place are appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers including definitions. The clinical leader/RN is the restraint coordinator and is knowledgeable regarding this role. During the audit there were no residents using a restraint or an enabler. Staff receive training around restraint minimisation and managing challenging behaviours. Care staff interviewed, understand the difference between an enabler and a restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>There are policies around the need to complete admission agreements on or before admission. Five of seven admission agreements reviewed meet contractual requirements.</p>	<p>One resident's admission agreement was not available on day of audit, and one resident's admission agreement was not signed on or before admission.</p>	<p>Ensure that all residents have a signed admission agreement on file signed for before or on admission.</p> <p>90 days</p>
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the</p>	PA Low	<p>The manager has a background in quality systems. She has been managing this aged care facility for the past six years and is supported by the directors and the clinical leader. The manager and director/s meets face-to-face each month. Professional development activities over the past year have included one meeting with the MidCentral District Health Board (two hours) and regularly attending the in-</p>	<p>The manager's professional development related to managing an aged care service does not meet contractual requirements.</p>	<p>Ensure the manager attends a minimum of eight hours annually of professional development relating to managing an aged care facility.</p>

provision of services.		house in-services.		180 days
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	<p>The current system for document control does not provide sufficient evidence to support that a full and complete review of policies has been undertaken. Cover sheets in the policy and procedures manual only states policies were 'reviewed in 2015'. The quality consultant reports that she is updating the document control process whereby policies will have a footer section to identify when the policy was issued and review dates. Policies and procedures are in the process of being linked to InterRAI processes.</p>	<p>The document control system does not provide specific information about when policies and procedures were last reviewed. Policies and procedures are not linked to InterRAI.</p>	<p>Ensure that a system is in place to manage policies and procedures to verify that documents are approved, up-to-date and reflect evidence of regular reviews. Ensure that the policy manual is updated to reflect the implementation of InterRAI.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Moderate	<p>Medication policies align with accepted guidelines. Medications are stored securely. The service uses robotic packs. Allergies are recorded on 14 of 17 medication charts reviewed. Medication charts have photo identification on 15 of 17 medication charts reviewed. There is a signed agreement with the pharmacy. Staff sign for the administration of medications on the medication signing sheet. The medication folder includes a list of specimen signatures.</p>	<p>(i) Three of seventeen medication charts reviewed (one dementia and two rest home) did not identify any resident allergies or nil known allergies. (ii) Four of seventeen medication charts reviewed (two rest home and two dementia) did not identify indication for use for 'as required' medication (PRN).</p>	<p>i) Ensure any resident allergies or nil known allergies are identified on the medication chart. (ii) Ensure that indications for use are identified for all as required medication (PRN).</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated</p>	PA Moderate	<p>The service schedules an activities programme in both the rest home and the dementia unit that is designed to meet the needs of specific</p>	<p>On the day of audit there were no activities taking place in the dementia unit as per an activity programme.</p>	<p>Ensure that there are appropriate activities organised in the</p>

<p>to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>residents and groups of residents. Resident feedback is used to improve the programme.</p>	<p>Two staff interviewed in the dementia unit stated that they did not know what the 'individual' activity identified on the activity programme was.</p>	<p>dementia unit and that caregivers working in the dementia unit are fully aware of their role in providing these activities.</p> <p>60 days</p>
<p>Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Low</p>	<p>A call bell system is in place in the residents' rooms and communal areas. Residents have access to their call bells in their rooms. Residents and family reported that call bells are answered by staff in a timely manner. Not all call bells were functioning as noted during the tour of the facility.</p>	<p>Three call bells in the shower/toilet areas were tested and were not working. The director immediately contacted an electrician who arrived during the audit to fix these calls bells and check all of the others. (It was discovered one resident is removing and stashing call bells with personal belongings. At the time of the audit they plugged other call bell in place that were not compatible with this area).</p>	<p>Ensure call bells are in working order at all times.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.