

# Lakeside Lodge Rest Home Limited - Lakeside Retirement Lodge

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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:** Lakeside Lodge Rest Home Limited

**Premises audited:** Lakeside Retirement Lodge

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 7 March 2016 End date: 8 March 2016

**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:** 30

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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

Lakeside Retirement Lodge provides rest home level care for up to 30 residents. On the days of audit there was full occupancy.

This certification audit was conducted against the relevant Health and Disability Standards and the agreement 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, staff and a general practitioner.

The rest home is owned and operated by the facility manager and the clinical manager. Both owners are registered nurses. They employ an additional two registered nurses and the activities coordinator is also a registered nurse although not practising currently. The rest home has a high registered nurse to resident ratio with stable staffing. There are established quality and risk management systems in place. Feedback from residents, family and the general practitioner was positive about the care and services provided.

There are two areas for improvement identified, which relate to the completion of interRAI assessments in a timely manner by the registered nurses and medication charting.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and where appropriate, their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Staff interviewed were aware of residents' rights. Policies are implemented to support residents' rights and cultural preferences are respected. Care planning accommodates individual choices of residents' and/or their family/whānau. There is a system of complaints management in place. Residents are supported to maintain links to the community and their families.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The facility and clinical managers ensure services are appropriate to meet the needs of residents according to the business plan. They provide the on-call cover for the premises if one of the other two registered nurses is not on duty. There is an established quality and risk management system in place that is being implemented. There is a monthly staff meeting that includes health and safety, infection prevention and control, discussion of quality and risk matters including adverse events. The roster provides sufficient and appropriate coverage for the effective delivery of care and support. Residents, family and staff interviewed stated that there is sufficient staff on duty at all times. Staffing is stable. There is an implemented orientation programme that provides new staff with relevant information for safe work practice and in-service training is held at minimum monthly.

## 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.
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Resident's needs are assessed prior to entry. There is a well developed information pack available for residents/families/whānau at entry. Assessments, care plans and evaluations are completed using interRAI. Short-term care plans are in use for changes in health status. There is a group activities programme running that is meaningful and appropriate for the residents and there is good interaction with the community. The activities coordinator is a registered nurse. There is an established system of medicines management in place. Food services policies and procedures are appropriate to the service setting. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. The kitchen is the hub of the rest home. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are accommodated.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There are documented policies and procedures in place for the management of waste and hazardous substances. The physical environment meets the residents' needs in terms of toilets, showers, personal space, communal areas, natural light, heating and ventilation. Documented policies and procedures are in place for cleaning and

laundry services. Staff have completed appropriate training in chemical safety. There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with civil defence guidelines.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The residents are of the level where enablers and restraints are not considered necessary. On the day of audit there were no residents using enablers or restraints. There are policies and procedures available should restraint become necessary and a procedure for dealing with residents who may exhibit challenging behaviours is also available. Residents requiring the use of restraints would be reassessed to determine their suitability to reside in the rest home.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is suitable for a facility of this type. The programme is led by the facility manager with support from the clinical manager and the registered nurses. The programme is based upon a clear set of policies and procedures that are available to guide staff. The general practitioner is actively involved in the management of residents with

suspected infections. Education is provided to staff on an ongoing basis and infection prevention and control is included in the internal audit programme. Infections are monitored and practice is reviewed every month. Trends can then be identified. There have been no recent outbreaks of infection in the rest home.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	43	0	2	0	0	0
<b>Criteria</b>	0	91	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has information available on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Advocacy pamphlets and the Code are clearly displayed at the main facility entrance. Eight residents and two relatives interviewed confirmed that information has been provided around the Code. There is a resident rights policy in place. Consumer rights training occurs. Discussion with three caregivers, the registered nurse and the clinical and facility manager identified that all were aware of residents' rights.</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</p>	FA	<p>The service has policies and procedures relating to informed consent, resuscitation and advanced directives. All six resident files reviewed included signed agreements including consents and resuscitation instructions. Staff are aware of advanced directives. Discussions with residents and families identified that the service actively involves them in decision making.</p>



consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents and families are provided with a copy of the Code and advocacy pamphlets on entry. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services. Caregivers interviewed are aware of the resident's right to advocacy services and how to access the information.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	The service has an open visiting policy. Family and friends are encouraged to visit the rest home and are not restricted to visiting times. All residents interviewed confirmed that relatives and friends are able to visit at any time. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the rest home as part of the activities programme. One resident on the day of audit was observed using their mobility scooter to access community resources independently.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	There is a complaints policy and procedure in place, which meets the requirements of the Code. The process is communicated to residents and their families on admission. Complaint forms are readily available. Staff are educated on the complaints process. There have been no complaints made in 2015 and 2016, year to date. Any resident concerns are actively addressed by the managers. Residents and family members interviewed advised that they are aware of the complaints procedure.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is a welcome information folder that includes information about the Code and the nationwide health and disability advocacy service. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The facility manager is available to discuss concerns or complaints with residents and families at any time. Residents and family members interviewed state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	The facility provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintained resident privacy and promoted resident independence. Staff sign a privacy declaration on

<p>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>employment. The facility manager is the privacy officer and has an open door policy.</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>There is a Māori health plan and ethnicity awareness policy and procedure in place. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The service has established a link with iwi through a local Māori elder/kaumātua who provides advice for staff and advocacy for Māori. On the day of the audit, there were two residents that identified as Māori and their cultural preferences were documented in their interRAI assessments and subsequent plans of care. One of these two residents was interviewed and was satisfied that staff followed specified cultural preferences and the resident stated that their whānau was equally satisfied with service delivery.</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 provides a culturally appropriate service by identifying any cultural needs as part of the interRAI assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular onsite church services, spiritual visitors and attending other community groups as desired. Staff are provided with ongoing cultural awareness training.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	<p>FA</p>	<p>The staff employment process includes the signing of a service code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Caregivers interviewed could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect.</p>

sexual, financial, or other exploitation.		
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The facility manager and the clinical manager are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the audit, with the staff demonstrating a very caring attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures to provide a good level of assurance that it is adhering to relevant standards. Staff have a sound understanding of principles of aged care and state that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The managers promote an open door policy. Relatives are aware of this policy and confirmed on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Communication is identified as an area of strength in the interviews with the residents and relatives. The facility manager contacts the family following an adverse event or change in the resident's condition (verified in eight accident/incident reports where evidence of relatives being contacted is documented). The resident/family satisfactions survey monitors satisfaction levels relating to families being kept informed.</p> <p>Interpreter services have not been needed. In the event it is necessary to utilise an interpreter, the facility manager would contact the Counties Manukau District Health Board (CMDHB) for assistance. Staff from different cultural backgrounds is available for assistance if needed. 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 Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Lakeside Retirement Lodge provides care for up to 30 rest home residents. On the day of audit there were 30 residents. All residents were being provided with services under the Aged Residential Care agreement. There were no respite or younger person residing at the facility or residents funded by other agencies. The facility manager is a registered nurse with a background in mental health. He has worked in aged care since 1996. He and his wife have owned Lakeside Retirement Lodge for the past 12 years. His wife who is a registered nurse with a background in cardiovascular nursing is the clinical manager. They both hold current practising certificates.</p> <p>The philosophy, mission, scope and goals of the service are defined in the quality manual and in the information pack that is provided to residents and their families during their admission to the rest home. The</p>

		<p>business plan for 2016 and 2017 includes quality indicators, person responsible and timeframe for implementation.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The facility manager and the clinical manager have completed interRAI training. The clinical manager attends professional development activities to maintain her registration and to keep her practice current.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the facility manager and his wife the clinical manger, the registered nurses and the senior caregiver/assistant manager are the acting managers.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a business, quality risk assessment and management plan. Quality is measured by maintaining high resident occupancy, retaining staff, through the internal and external auditing programmes and through monthly staff meetings. The facility manager is responsible for the quality management programme. The service has in place a range of policies and procedures to support service delivery that are reviewed regularly. The staff have input into the staff meetings, where there is discussion around complaints, compliments, health and safety, infection prevention and control, audit and survey results, corrective actions and improvements. Staff interviewed state they are well informed and receive quality and risk management information such as accident/incident graphs and infection control statistics. Quality data comes from a number of sources, including internal audits, incidents and accidents, infections and client feedback. Results of adverse events are monitored and collated each month. The results are discussed by management and in staff meetings. There is an internal audit programme that is conducted on a quarterly basis that meets the requirements of the internal audit schedule. Infection rates and incidents/accidents are audited monthly. The risk management plan identifies risks to the facility.</p>
<p>Standard 1.2.4: Adverse</p>	FA	<p>There is an accident/incident policy in place to guide staff. The service collects accident and incident data and</p>

<p>Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>reports results monthly at the staff meeting. The caregivers interviewed could discuss the reporting process. The accident and incident forms reviewed were fully and appropriately completed. Family members interviewed stated they were informed of incidents/accidents involving their relatives.</p> <p>The facility manager is aware of his statutory reporting obligations. There have been no serious adverse events, coroner's investigations or complaints received by the service.</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 in place to support good employment practices. The facility manager, clinical manager and registered nurses (RNs) practising certificates are current. Five staff files were reviewed (one RN, one caregiver, one activities coordinator, one cleaner and one cook) and all had relevant documentation relating to employment. There are job descriptions in place. All files contain evidence of staff attendance at education and training sessions, employment contracts, job descriptions and up to date performance appraisals. The facility manager has a performance appraisal schedule in place.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Caregivers interviewed were able to describe the orientation process and believed they were adequately orientated to the service. An education programme is in place and training occurs at least monthly. All caregivers interviewed who work across all three shifts report that they have good access to education and training programmes internally and externally. Caregivers administering medications are assessed as competent by a registered nurse. There is a first aid trained staff member on site at all times. The activities coordinator has a current first aid certificate and driver's license.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The human resources policy determines staffing levels and skill mix for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical manager are both RNs who work five days a week (Monday – Friday) on a full time basis. A third RN is on duty three days a week covering both the AM and PM shifts. This RN also covers in the absence of the facility manager and his wife (clinical manager). An RN is either on-site or on-call 24 hours a day, 7 days a week. In addition to the RN cover, there are three caregivers rostered on the morning shift, two caregivers on the afternoon shift and two caregivers on the night shift. Caregivers assist with laundry duties. There is separate cleaning staff and a part-time activities coordinator who is employed Monday to Friday from 9.00 am to 12.30 pm with flexible hours depending on the activity programme. The caregivers interviewed report that the staffing levels are adequate and that staffing is increased if the resident acuity increases.</p>

		Interviews with family confirmed that they believe staffing is adequate to meet the needs of the residents.
<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	Resident files are a mix of hard and soft copy and are appropriate to the service. Residents entering the service have all relevant initial information recorded on admission. Information containing personal resident information is kept confidential. All entries in the progress notes were appropriately recorded.
<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	There is a policy in place to guide resident admissions. Needs assessments are required prior to entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding care requirements. There is an information pack provided to all residents and their families on admission outlining services available. Residents and or family/whānau are provided with associated information (eg, information on their rights, the Code, complaints management, advocacy and the admission agreement). Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. The current version of the admission agreement aligns with the expectations in the aged residential care agreement and includes exclusions from the service.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	The service has transfer and discharge policies and procedures in place. The procedures include the use of the DHB developed (i.e., 'yellow envelope') system to manage information during transfer and discharges. All residents transferred or discharged are noted on interRAI by the registered nurse.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	PA Low	All medicines are prescribed by the in-house GP (confirmed in review of 12 of 12 residents' medicine charts). The prescribing of 'as required' medicines does not meet the requirements of the Medicines Care Guides for Residential Aged Care. All medication charts have dated photographic identification and allergy status is recorded. Medicines are administered as prescribed by either a RN or medicine competent caregiver (medicine round observed). All medicines that have been administered are correctly signed for by the administering staff

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>member. All medicines are stored securely when not in use and there is a dedicated medicine refrigerator on-site. The facility uses the blister pack medication management system. Medicines are delivered every four weeks usually unless additional medicines are needed. Medicines are reconciled on delivery by a RN or competent caregiver prior to use. All medication charts are legible and reviewed three monthly. The pharmacist conducts a formal stock take on-site of medicines at least every six months. There are appropriate medication policies and procedures in place including policy for residents who self-administer their medicines. There are no residents self-administering medicines currently. Only registered nurses and senior caregivers who are considered competent administer medicines. Competency is assessed annually when due. Education on medicine management is ongoing.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The facility employs four kitchen staff (two cooks and two kitchen assistants) who covers all shifts. (The main cook was interviewed). The kitchen is staffed from 6.45 am to 3.15 pm and 2.45 pm to 6 pm, seven days a week. Both cooks have completed food safety education. The majority of food is prepared and cooked on site. Daily monitoring records are maintained of food temperatures and refrigeration and freezer temperatures. Food is served directly to residents in the adjoining dining room. Food services policies and procedures are appropriate to the service setting. There are four weekly menus in place that have been approved by a dietitian. Food is purchased from commercial suppliers who deliver to the site. There is sufficient refrigeration on site to store food safely. The cooks have the ability to cook with gas or electricity. Residents' dietary profiles are stored in the kitchen. Resident preferences are accommodated. Special equipment is available as needed. Additional fluids and food are available for residents when the kitchen is closed. There are no residents requiring special diets at present. The kitchen stocks at least a weeks worth of food for use in an emergency. Residents and family members interviewed were complimentary of the food service provided.</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>	<p>FA</p>	<p>The service has a process for declining entry should this be necessary. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. Management reported that they have not had to decline entry to prospective rest home residents provided the facility has a vacancy. The reason for declining service entry to residents would be recorded and communicated to the resident/family/whānau and alternative options suggested if appropriate.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>An initial nursing assessment and initial care plan is completed within 24 hours of admission by the registered nurse. Personal needs, outcomes and goals of residents are identified. There are a range of assessment tools completed on admission which include a general assessment, a pain assessment, a continence assessment, a Coombe falls risk assessment and a Braden risk of pressure injury assessment. All new residents admitted have an interRAI assessment (link 1.3.3.3). The assessment tools link to the individual care plans. Cultural needs are recorded in the interRAI LTCF in the section related to language.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The interRAI assessment, assessment summary (which includes triggered clinical assessment protocols (CAPs), outcome scores and the needs identified by the registered nurses clinical judgement; informs the development of the care plan. All six care plans reviewed referenced the identified CAPs. Comprehensive long-term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Residents and family members interviewed stated they are involved in the care planning process. All resident comprehensive long-term care plans reviewed were evidenced to be up to date. All care plans reviewed recorded sufficient detail to guide care staff. Individual activities plans were completed for all files reviewed. Short-term care plans are used where appropriate and are typically used for residents with infections or skin tears.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Service delivery is guided by the resident's plan of care. Care plans are goal orientated and reviewed at six monthly intervals. The review dates are recorded in the interRAI documentation.</p> <p>The three caregivers and the registered nurse interviewed stated that they have sufficient equipment to provide care, including wheelchairs, walking frames, standing scales; which are provided by the facility. Clinical supplies are available with adequate supplies of wound care products, continence products, blood glucose monitoring equipment and other medical equipment. Resident weights are monitored monthly or more frequently if necessary. Specialist nursing advice is available from the DHB as needed. All residents who fall have a completed resident accident/incident form and the fall is reported to the RN and/or the clinical manager. A falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral to the community physiotherapy service can be initiated as required.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>An activities coordinator is employed from 9 am to 12.30 pm Monday to Friday with additional flexible hours depending on the planned activity. Hours are extended based on the programme (confirmed in discussion with</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>the activities coordinator). The activities coordinator is a non-practising registered nurse with a background in aged care and a background as a special needs assistant teacher. All residents have an individual activities plan developed shortly after admission. They can choose to participate in the group programme or they are encouraged to choose an activity from their individual programme. The individual activity plan is reviewed when the care plan is reviewed. There is flexibility in the programme for offsite group activities (e.g., van rides). The programme includes outside entertainers who visit the premises. The residents are vocal regarding their expectations and preferences. There are three communal areas where group activities can be held which include the lounge, the adjoining dining room and the outside deck. Residents enjoy interacting with the activities coordinator (confirmed by observation and in discussions with residents and families).</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI process at least six monthly or if there has been a significant change in their health status. Paper-based reviews of care plans were evidenced as the provider has been completing three monthly reviews to date. Care plan reviews are signed as completed by the RN. The GP reviews residents three monthly or when requested if issues arise or their health status changes and they are not considered medically stable. The GP was interviewed and stated that the staff communicate appropriately. Short-term care plans are in use.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to medical and non-medical services. The facility and clinical manager confirmed that residents, family and the resident's GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the registered nurse. Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and</p>	<p>FA</p>	<p>There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Product use information is available. Protective equipment including gloves, aprons and goggles are available for use by staff. Staff interviewed were familiar with accepted waste</p>

service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		management principles and practices.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness that expires 1 June 2016. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the resident group. There is a reactive and proactive maintenance system in place that is overseen by the facility manager. Annual calibration and functional checks of medical equipment were completed in February 2016. The weighing scales were tested in October 2015. Electrical testing has just been completed in February 2016. The building does not have a hoist. Hot water temperatures in resident areas are monitored quarterly and are stable between 43-45 degrees Celsius. Contractors are available 24 hours a day for essential services. Residents are provided with safe and accessible external areas that meet their needs. There is flat access to external areas and the deck.
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	Toilet and shower facilities are of appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored six monthly. Recent temperature readings show that hot water temperatures are maintained at 45 degrees Celsius or just below. The communal toilet has a system that indicates if it is engaged or vacant. Residents and family members interviewed report sufficient number of showers.
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal	FA	All rooms are individual with their own ensuite, toilet and hand basin. Adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. Rooms are of sufficient size to accommodate walking aids.

space/bed areas appropriate to the consumer group and setting.		
<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>Adequate access is provided to two lounges, the dining and other communal areas and residents are able to move freely within these areas. Residents interviewed confirm 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.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning policy and procedures and laundry policy and procedures are available. Chemical safety data sheets for all chemicals used in the facilities are available. Staff has access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. Cleaning is performed by a cleaner who is employed 9am to 3pm Monday to Friday (interviewed). Caregivers do 'spot' cleaning on the weekends. Laundry is performed by the caregivers on each shift. All laundry is done in house. The effectiveness of the cleaning and laundry systems is monitored through the internal audit programme which is run by management. Residents and family interviewed state their satisfaction with the cleaning and laundry services.</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>	FA	<p>An approved evacuation scheme was signed off by the New Zealand Fire Service on 14 February 1995. There are policies and procedures on emergency and security situations. These policies have been reviewed within the last year. Interviews with the facility and clinical manager and caregivers confirm staff are aware of emergency and security procedures. Fire training and security situations are part of orientation of new staff and emergency drills occurs six monthly. Fire equipment is available and a fire services company conducts monthly checks. All senior staff and registered nurses have current first aid certificates and there is a staff member on duty at all times with a current first aid certificate as confirmed on rosters sighted.</p> <p>The facility has adequate supplies of blankets, water, food and emergency lighting for use in an emergency. The kitchen can cook by gas or electricity. There is at least three days supply of food stored on site.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. All staff are aware of the emergency process. Residents are orientated to the call bell system on admission to the facility (confirmed by</p>

		<p>six residents interviewed).</p> <p>Security policies and procedures are documented and implemented by staff. Afternoon and night staff ensures all outside doors and windows are securely locked. There is security lighting for after dark and security cameras on the property. All staff interviewed are familiar with security measures.</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>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The responsibility for infection prevention control is held by the facility manager (owner) who is a registered nurse with a current practising certificate. He is supported by the clinical manager and other registered nurses. There are clear lines of accountability for infection prevention and control matters in the organisation. There is a clearly defined and documented infection control programme that is reviewed annually. Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious where possible. There is signage on the front door of the building and staff advise non-residents who appear sick to go home until they are well enough to return.</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</p>	FA	<p>The infection prevention and control team consists of the IPC coordinator who is assisted by the clinical manager and other registered nurses. The team have access to the GP and staff from the DHB infection prevention and control team if needed.</p>

organisation.		
<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 a range of written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. Policies and procedures are reviewed by the IPC team.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Education on infection prevention and control is provided to staff by the IPC coordinator who is considered suitably qualified. The IPC coordinator has completed the Ministry of Health online education on IPC (in 2015) and maintains knowledge of current practice by attending the ongoing education in infection prevention and control offered by Care Association of New Zealand. Resident education occurs as applicable.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There are documented policies and procedures in place to cover ongoing surveillance and the management of outbreaks. Any resident who is suspected of having an infection is reviewed by a registered nurse and the general practitioner. Specimens are taken as appropriate and sent to the laboratory and a record of this action is maintained in the resident's clinical record. Results are received, considered and documented. A record of all suspected and actual infections is maintained. This information is collated, analysed and reported at the monthly staff meeting. Trends can then be identified and further preventive action taken if required. The rest home does not have a high infection rate. Typically infections are limited to urinary or chest infections. There have been no outbreaks of infections since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The registered nurses oversee the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service currently has no residents using enablers or restraints. Any resident requiring restraint or who exhibited behaviours that may challenge would be reassessed to determine their suitability to continue to reside in the rest home.</p>
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## 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 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and	PA Low	In the sample of 12 medicine charts reviewed, the GP was charting medicine orders correctly for regular medicines and short course medicines. 'As required' medicines were correctly charted in three of twelve medicines charts reviewed.	“As required” medicines were not correctly recorded by the GP in 9 of 12 medicine charts reviewed. Target symptoms and the rationale for using the as required medicines were not listed by the GP. The indication of the frequency and dose range were not recorded as specified in the Medicines Care Guides for Residential Aged Care.	Ensure the GP charts as required medicines according to the Medicine Care Guides for Residential Aged Care.  60 days

guidelines.				
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>All residents are assessed on admission and an immediate plan of care is developed. Further assessment occurs depending on the resident's needs and specialist assessment tools are used to assess risk (eg, pain assessments, Braden and Coombes). Five of the six residents in the sample of clinical records reviewed had been admitted since 1 July 2015 when the requirement to complete interRAI assessments formally commenced. Only one of the five residents in the sample of six residents had been assessed using the interRAI process within 21 days of their admission and that was the most recent admission. The sixth resident was admitted prior to 1 July 2015. All six residents had been assessed using interRAI. Management were aware that there had been delays with completing interRAI assessments on all residents</p>	<p>Four of five residents admitted since 1 July 2015 did not have an interRAI assessment completed within 21 days of admission. However their interRAI assessments were completed shortly thereafter.</p>	<p>Ensure all residents that are admitted have an interRAI assessment completed within 21 days of admission.</p> <p>90 days</p>



## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.