

Holly Lea Village Limited - Holly Lea

Introduction

This report records the results of a Provisional 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:	Holly Lea Village Limited
Premises audited:	Holly Lea
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 March 2016 End date: 31 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:	6

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Holly Lea is certified to provide rest home level care for up to 21 residents within a retirement village complex. On the day of audit, there were six rest home residents. The general manager is an experienced manager and registered nurse, who has been in the role since December 2015. A board, a business manager and a clinical manager support the general manager. The quality management system in place is designed to identify opportunities for improvement. Residents and families interviewed were complimentary of the service that they receive. Staffing levels have been rationalised since the change of governance.

This certification audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The audit has identified that improvements are required around interRAI assessment policy and use of the interRAI assessment tool.

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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The staff at Holly Lea strives to ensure that care is provided in a way that focuses on the individual and residents' autonomy is valued. Information about the Code of Rights and services is easily accessible to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

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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The general manager is a registered nurse and reports to the regional business manager and the managing director of Generus Living Group. There is a clinical nurse manager, registered nurses and care staff. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are implemented, followed through and communicated to staff. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. Staff advised that there is an orientation programme that provides new staff with relevant information for safe work practice. Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial care plans, specific assessments and care plans to guide staff in the delivery of care to residents. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three monthly general practitioner review.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. Registered nurses and senior healthcare assistants administer medications. There is a comprehensive policy for medication management, administration and storage.

Residents' food preferences and dietary requirements are identified at admission and all meals prepared on-site. The kitchen is well equipped for the size of the service. This includes consideration of any particular dietary preferences or needs.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness. Furniture and fittings are selected with consideration to residents' abilities and functioning. Furniture is appropriate to the setting and arranged that enables residents to mobilise. The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Laundry and cleaning processes are monitored for effectiveness. The service has implemented policies and procedures for fire, civil defence and other emergencies. There is staff on duty with a current first aid certificate. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

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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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Staff are trained in restraint minimisation and safe practise. There were no residents with restraint and one resident with an enabler.

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 control programme is appropriate for the size and complexity of the service. The infection control officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities.

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	43	0	2	0	0	0
Criteria	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)
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>Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (two healthcare assistants, one registered nurse, one activities coordinator, the clinical manager and the general manager) confirm their familiarity with the Code. Interviews with five residents and one relative confirm the services being provided are in line with the Code of Rights.</p> <p>Code of Rights and advocacy training has been provided. The management team confirms familiarity with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>A detailed informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and decisions. The healthcare assistants interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p>

		Consent forms were signed and dated appropriately. The admission agreements reviewed were signed and dated by the provider and the resident and/or representative. The obligations and legislative requirements are met to ensure competency of residents as required for advance directives and advance care planning. Resident reviews were undertaken six monthly. Reviews of the individual resident's health status were documented and retained in each personal file reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. The residents' files include information on residents' family/whānau and chosen social networks. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry. Discussion with a relative identifies that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The resident information pack states that visiting can occur at any reasonable time. Interviews with residents and relatives confirm that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verify that they are supported and encouraged to remain involved in the community. Holly Lea staff support ongoing access to community and entertainers are invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Information on the complaints forms includes the contact details for the Health and Disability Advocacy Service. Interviews with residents and relatives are familiar with the complaints procedure and state any concerns or issues are addressed.

		<p>The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. Complaints for 2015 and 2016 were reviewed. A full investigation of all complaints has been conducted and resolutions obtained which included staff performance management as required. Complainants are advised in writing of the outcomes of the investigations within the required timeframes. Advised that resident meetings are an open forum for residents to air any concerns or issues which are then dealt with in a timely manner.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that include the Code of Rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identify they are informed about the Code of Rights. The general manager and clinical manager provide an open-door policy for concerns or complaints. Resident meetings have been held, providing the opportunity to raise concerns in a group setting. A resident satisfaction survey has been conducted. The survey includes questions relating to complaints process and residents' rights, with respondents reporting they were overall satisfied or very satisfied. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. House rules and a code of conduct is signed by staff at commencement of employment. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful. Residents' files include their cultural and/or spiritual values when</p>

		identified by the resident and/or family. Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Staff education and training on abuse and neglect has been provided.
<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>	FA	<p>There is a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. There is information and websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training has been provided for staff.</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>	FA	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to resident meetings and facility functions. The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse.</p> <p>Care plans reviewed include the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules and a Holly Lea code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries, evidenced in interviews with staff and the general manager. Interviews with staff confirm their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The 2015 resident satisfaction survey</p>

		<p>reflects high levels of satisfaction with the services that are received. The general manager has been responsible for coordinating the internal audit programme. Policies and procedures have been reviewed. New and updated policies have been provided since change in governance. There are staff meetings and residents' meetings conducted.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they are well supported by management. There are implemented competencies for healthcare assistants and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</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>Policies are in place relating to open disclosure. Residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>A sample of incident reports reviewed and associated resident files, evidenced recording of family notification. The relative interviewed confirmed that they are notified of any changes in their family member's health status. The general manager and clinical manager were able to identify the processes that are in place to support family being kept informed.</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. 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. The facility has an interpreter policy to guide staff in accessing interpreter services.</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>Holly Lea provides rest home care to up to 21 residents within a 38-apartments complex. On the day of audit, there were six rest home residents. There were no respite residents. All residents were under the age related contract.</p> <p>This audit included an interview with the general manager of Holly Lea and the regional business manager of Generus Living Group. The business manager has a background in hotel management and oversees Holly Lea and one other local retirement village. The general manager (GM) is a registered nurse and is experienced in aged care and in</p>

		<p>management. The GM has been in the role since December 2015.</p> <p>The Generus Living Group took control of the management of Holly Lea in July 2015. At that time, transitional managers were employed to manage the change in governance structure and to review staffing and financial management. The clinical manager commenced her role at Holly Lea in February 2016.</p> <p>There is a business plan for 2016 and a quality and risk management programme being implemented for 2016. The organisational structure includes a board made up of Generus Living Group personnel and previous members of the McLean Institute trust. The general manager reports to the business manager and the Generus Living Group managing director.</p> <p>The general manager has maintained at least eight hours of professional development in relation to management of 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>	FA	<p>In the absence of the general manager, the clinical manager is in charge with support from the business manager and care staff.</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>	PA Low	<p>The quality management manual includes the quality and risk management plan and service philosophy. The quality programme has been reviewed by the general manager and new goals and quality indicators have been set for 2016. The quality and risk management plan has documented aims and objectives. The internal audit schedule and internal audits are being completed. Corrective actions have been developed where compliance is less than expected and corrective actions evidence full completion. Staff meetings have been held with evidence of discussion of quality outcomes. Management meetings and resident meetings have also been held.</p> <p>A resident and relative survey has recently been conducted with respondents advising that they are overall very satisfied with the care and service they receive. A survey evaluation has been conducted for follow up and corrective actions required.</p>

		<p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. The service has a health and safety management system and hazard registers are maintained. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.</p> <p>There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.</p> <p>There is an annual staff training programme implemented that is based around policies and procedures. Records of staff attendance and participation have been maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The general manager and clinical manager are in the process of reviewing all policies and procedures. Existing policies are current with the exception of the resident assessment policy.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and an analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. Either a registered nurse or a healthcare assistant commences incident/accident forms. Progress notes reviewed for a sample of residents' evidence that all incidents and accidents had been reported. Follow up by a registered nurse is evident in the entire sample of resident incident forms reviewed and corresponding residents' notes. Discussions with the general manager and clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification to the MOH was reviewed. There is an open disclosure policy and family members interviewed stated they are informed of changes in health status and incidents/accidents. Family notification was recorded on incident forms, on family contact sheets and in progress notes.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources management policies in place that includes recruitment and staff selection process. Policy requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. The human resources policies also include orientation, staff training and development. Six staff files were reviewed (one clinical manager, one registered nurse, one activities coordinator and three healthcare assistants) and evidence that reference checks are completed before employment was offered. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. All files evidenced had completed staff file documentation including staff appraisals. Staff were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service.</p> <p>Discussion with the general manager, clinical manager and staff confirms that in-service training has been provided since the previous audit. Training has included a healthcare assistant online training programme and face-to-face sessions. There is an in-service calendar for 2016. The annual training programme exceeds eight hours annually.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The general manager and clinical manager work full time. There are two registered nurses – one works full time and one works part time. There are at least two healthcare assistants on duty at any one time. The clinical manager and registered nurses provide after hours on call cover. A full roster review has been conducted in consultation with individual staff members. Staffing levels have been rationalised. Interviews with staff, residents and a family member identify that staffing is adequate to meet the needs of residents.</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>	<p>FA</p>	<p>The resident 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. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Information containing sensitive resident information is not displayed in a way that can</p>

		<p>be viewed by other residents or members of the public. File entries are legible, dated and signed by the relevant healthcare assistant or registered nurse.</p> <p>Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</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 entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident's sampled records. Admission agreements reflect all the contractual requirements. Residents and families reported that the admission agreements were discussed with them in detail by the clinical manager or general manager. All residents had the appropriate needs assessments prior to admission to the service. A pamphlet containing information about the service was sighted. The clinical manager ensures that residents are admitted to the service as per contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>A standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The yellow envelope is utilised with the transfer notification form. The clinical manager verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>An appropriate medicine management system is implemented to ensure that the residents receive medicines in a safe and timely manner. All prescribed medications were reviewed by the GP in a timely manner. Medicine reconciliation is conducted by the clinical manager when a resident is discharged back to the service. Medication charts complied with all legislative requirements, professional obligation and best practice.</p> <p>The staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medication rounds. Current medication competencies were evidenced in the staff files.</p> <p>The system in place for the management of controlled drugs meets the</p>

		<p>required regulations and guidelines. The controlled drugs register was correct and the clinical manager or registered nurse conducts a weekly stock take.</p> <p>All medications were stored appropriately.</p> <p>There were no residents self-administering medication. The self-administration policies and procedures were in place. Standing orders reflected best practice and was signed by the GP as current.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked on-site by the catering manager and second cook. There was evidence of current food handling certificates.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. The registered nurse completes the dietary requirement forms on admission and provides a copy to the kitchen. The kitchen board is updated regularly. Additional or modified foods are also provided by the service. There are several additional options available on a well presented menu. The four weekly menus were recently reviewed at national level.</p> <p>Fridge and food temperatures were monitored and recorded daily. Cooked meals are plated from the kitchen to the dining room. The meals were well presented and residents confirmed that they are provided with alternative meals as per request. Resident satisfaction surveys confirmed general overall satisfaction with the meal service. All residents are weighed regularly. Residents with weight loss problems are provided with food supplements or referral to a dietitian.</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>There is a documented policy on decline of entry to the service. When a resident's entry to the service is declined, the resident is referred back to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The clinical manager reported that the district health board needs assessors and social workers contact the clinical manager to discuss the suitability of the resident prior to sending the resident's family to view the facility.</p>
<p>Standard 1.3.4: Assessment</p>	PA Low	<p>The registered nurses utilise standardised risk assessment tools on</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>admission and this assessment information forms the basis of the resident's initial and long-term care plans. Assessment of resident risks and needs were documented and reviewed in a timely manner. InterRAI assessment tool and the outcome scores are used as the focus of the long-term care plans. InterRAI assessments were not consistently completed. Residents interviewed stated that they are consulted when assessments occur.</p> <p>The general manager and clinical manager interviewed are familiar with the contractual requirements and the interRAI process.</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 long-term care plans reviewed were resident focused and personalised. There was evidence that continuity of service delivery is promoted. Goals are specific and measurable. Long-term care plans are reviewed and updated in a timely manner. Short-term care plans are developed and evident in the sampled files. Interventions were sufficiently detailed to address the desired outcome/goal. Residents and families are involved in the development of long-term care plans. Staff members are informed about changes in the care plans and they are familiar with the needs of the residents. Integration of records and monitoring documents are well managed.</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>Care plan documentation was comprehensive. The interventions in managing acute health issues including wounds were documented in a short-term care plan.</p> <p>Interventions are updated when the desired goals/outcomes are not met or when the resident's response to the treatment is not satisfactory. Residents interviewed expressed satisfaction with the clinical care and that they are involved in the care planning. Healthcare assistants, a registered nurse and the clinical manager interviewed advised that there is adequate equipment provided including continence and wound care supplies. There were three skin tears and one abrasion recorded in the wound register. Wound assessment forms, an ongoing assessment and treatment forms were consistently completed for all wounds.</p> <p>Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The activities coordinator has adequate experience for the role and develops the annual activity plans with the residents when able.</p> <p>The weekly activities are posted in the rest home. Activities are planned for three times a week for a total of fifteen hours to assist with the resident's preferred activities and interests. The resident's activities participation log was sighted. The activities coordinator interviewed stated whenever a resident do not want to participate in group activities, one on one time is allocated. Residents interviewed verbalised the activities provided by the service are adequate and enjoyable. This was also evident in the resident satisfaction survey. Individual activity plans are reviewed six monthly to reflect their current interest.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans were reviewed and evaluated every six months or earlier as required. The interventions in both long-term and short-term care plans are modified when the outcomes are different from expected. Recent reassessments have been completed using the interRAI tool with the exception of one file (link 1.3.4.2.) The interviewed residents and family members reported they were involved in all aspects of care and reviews/evaluations of the care plans. The family are notified of GP visits and three monthly reviews by phone call and if unable to attend, they are informed of all the changes. There is at least a three monthly medical review by the medical practitioner.</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>	FA	<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. Internal referrals are facilitated by the clinical manager. Residents can voluntarily access or request referral to other services for example optometrists, hearing specialist.</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</p>	FA	<p>There are documented processes for the management of waste and hazardous substances and incidents are reported on in a timely manner. Material safety data sheets are available and accessible for staff. The hazard register is current. Staff have been provided with training and</p>

<p>substances, generated during service delivery.</p>		<p>education to ensure safe and appropriate handling of waste and hazardous substances. The staff orientation process addresses chemical usage, hazard management and the use of material safety data sheets.</p> <p>There are appropriate protective clothing and equipment that are used in management of waste or hazardous substances. Hazardous substances are correctly labelled and securely stored.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness, which expires on 1 November 2016. Maintenance books and records were sighted. Testing and tagging of electrical equipment has been completed. Medical equipment has been calibrated and serviced by an external provider. Fixtures and fittings are appropriate to meet the needs of the residents. Hot water temperature checks are conducted and recorded monthly. The interior is well maintained with each apartment furnished to a high standard. There are a number of communal rooms including a large music, a morning, two sun lounges and a spacious dining area. Each apartment has its own bathroom. There are small seating nooks available for residents and visitors. The facility is set in large grounds with covered external garden areas, which all residents can access. The external area is free from hazards. The basement houses a large garage, which residents of the village access through a swipe card system. The garage is gated and secure. There is a maintenance plan for the up keep of the interior and exterior of the complex. Interviews with three healthcare assistants confirmed there was adequate equipment to carry out the cares according to the resident's needs as identified in care plans. The service has one standing hoist and one sling hoist.</p> <p>Staff interviewed confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. There is a maintenance team including gardeners and external contractors. The plan is for each apartment to be completely refurbished. Work is currently underway in two apartments. Family and residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.</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</p>	<p>FA</p>	<p>There are adequate numbers of communal and visitor toilets with access to a hand basin and paper towels. Each apartment has its own full ensuite. Privacy locks are attached to bathroom doors. Facilities were</p>

personal hygiene requirements or receiving assistance with personal hygiene requirements.		viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Residents interviewed state their privacy and dignity are maintained while attending to their personal cares and hygiene. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The resident's apartment bedrooms are spacious and appropriate to the needs of the residents. Resident and family interviews confirmed this view. Resident's rooms are decorated with personal belongings in order to allow the residents to feel at home and have a sense of belonging. Mobility aids can be managed in the rooms, confirmed at the healthcare assistant's interviews. All rooms have adequate space to accommodate resident's mobility needs and safety requirements.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Holly Lea has a café, a music room, a morning room and a large dining room. Each apartment has a kitchen, lounge area and either one or two bedrooms. There are sufficient areas for residents to sit and meet with their family or friends, confirmed at the resident and family interviews and sighted during the tour of the facility. Group entertainment and activities are conducted in any one of the lounges and residents have enough space to mobilise with safety.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The laundry is large with a dirty and clean laundry flow. Laundry and cleaning services have been monitored for effectiveness and this was confirmed with the general manager. Personal laundry is completed in the resident's apartment. Each apartment is also fitted with a washing machine and dryer. The main laundry processes kitchen laundry and extra linen. An external laundry service processes towels and sheets. Laundry services and cleaning audits have been completed. Cleaning chemicals were securely stored in a lockable cupboard. Chemical safety data sheets are held and care staff (who complete the personal laundry service) receive training around the use of the chemicals. The residents and their family members confirmed they are happy with the management of their laundry. Visual inspection evidences the implementation of cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	There are emergency management plans in place to ensure health, civil

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>defence and other emergencies are included. Emergency management training is provided to all staff during orientation and induction and as part of their ongoing training programme. Training includes fire drills and emergency evacuation drills that have been provided on a six monthly basis. Civil defence resources are available. There is an emergency management manual and a fire and evacuation manual. An external contractor provides fire system monitoring and maintenance. There is at least one staff member on every shift that holds a first aid certificate.</p> <p>The New Zealand Fire Service approved the fire evacuation scheme on 25 August 2006.</p> <p>The facility has emergency lighting and a gas BBQ for alternative cooking. Emergency food and water supplies are maintained and are sufficient for at least three days.</p> <p>A call bell system is available in all areas including bedrooms, toilets, bathrooms and communal lounges and dining areas. The building is secured during the hours of darkness. Staff on afternoon duty conduct security checks. The basement garage is secured by a locked gate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is heated via a mixture of heat pumps, underfloor heating and individual heating panels in resident's rooms. The facility is bright and airy and rooms are well ventilated and light. All bedrooms have external windows. On the day of the audit, indoor temperature was comfortable and resident and staff interviews confirmed that the facility is maintained at a comfortable temperature. The facility has a ventilation system, which automatically responds to external and internal temperature changes.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme was appropriate for the size and complexity of the service. An infection control responsibility policy included chain of responsibility and an infection control officer job description. The clinical manager (RN) is the IC officer. The infection control programme was linked into the quality management system. The infection control meetings were combined with staff meetings. The IC programme is set out and reviewed annually with input from the management. The facility had developed links with the GP's, local laboratory, the infection control and public health departments at the local DHB.</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>The infection control team was appropriately configured for the size of the facility. The facility also had access to an infection control nurse specialist, public health and GP's.</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 were comprehensive infection control policies that were current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These were recently reviewed. The infection control policies link to other documentation and cross reference where appropriate. There are policies for IC management, implementing the IC programme, education, surveillance and IC policies and procedures related to the prevention and transmission of infection.</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>The infection control officer is responsible for coordinating/providing education and training to staff. The infection control officer (clinical manager) has completed appropriate training for the role. The induction package for new staff included specific training around hand washing and standard precautions. Training has also been provided as part of the annual training schedule. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. 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. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at management and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the general manager. Systems in place are appropriate to the size and complexity of the facility. No outbreaks have been reported since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	FA	<p>The facility is restraint free. The clinical manager is responsible for restraint review and use should this occur. There were no residents on</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>restraint on the day of the audit. There was one resident recorded as using an enabler (bedrail) at night, this was requested voluntarily to promote safety and independence. The use of the enabler was recorded in the care plan. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Enablers are voluntary. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</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)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	A full documentation review was conducted on site. The general manager and the clinical manager have reviewed a number of policies including pressure injury prevention and management, falls prevention and management, medication management, clinical policies, pain assessment and resident review. The resident assessment policy was last reviewed in 2015. There is no reference to the use of the interRAI assessment tool.	The resident assessment policy does not include reference to the interRAI assessment tool.	<p>Provide evidence that the resident assessment policy and associated resident care planning policies include reference to the use of the interRAI assessment tool.</p> <p>90 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	The new appointed clinical manager, general manager and registered nurse are interRAI competent assessors. InterRAI LCTF assessments and re-assessments have been completed for three residents. Where an interRAI assessment was due, but not completed, standardised assessment tools were completed and current. One new	InterRAI LCTF assessments have not consistently been completed as per contractual requirements.	<p>i) Ensure all new residents admitted have an interRAI assessment completed or in progress (effective from July 2015) and; ii) Ensure all reassessments are completed using the interRAI LCTF (</p>

		<p>resident did not have an interRAI assessment completed or in progress, however standardised risk assessment tools were completed. Another resident who was due for a re-assessment did not have an interRAI tool completed however; standardised risk assessments were completed for this resident. Cultural, sexuality and intimacy needs have been identified for the residents.</p>		<p>effective January 2016).</p> <p>60 days</p>
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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.