Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa

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:	Golden Age Rest Home Limited
Premises audited:	Albarosa Rest Home||Camellia Court Rest Home||Golden Age Retirement Village
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 May 2016 End date: 3 May 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: 118

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

Golden Age Rest Home Ltd is part of the Golden Healthcare Group (GHG). The service is certified to provide rest home and dementia level care for up to 133 residents across three facilities – Golden Age Rest Home, Camellia Court dementia unit and Albarosa dementia unit. On the days of audit there were 118 residents. Each facility manager is supported by registered nurses and care staff. The managers are all experienced in aged care management. The managers are also supported by a GHG clinical manager, quality assurance manager, operations manager, human resource & compliance manager and corporate services manager. Staff interviewed and documentation reviewed identified that the service continues to provide services that are appropriate to meet the needs and interests of the resident group. Family interviewed all spoke positively about the care and support provided.

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

The audit identified that improvements are required around staff designation in clinical records, timeliness of assessments, care plan evaluations 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.

Golden Age Rest Home Limited provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

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.

Golden Age Rest Home Limited, including Golden Age Rest Home, Camellia Court dementia unit and Albarosa dementia unit, has an established quality and risk management system that supports the provision of clinical care and support. Quality data is collated for accident/incidents, infection control, internal audits, concerns, complaints and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. An education planner covers compulsory education requirements over a two year period. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Family interviewed confirmed that the care plans are consistent with meeting residents' needs and were happy with the care. Planned activities are appropriate to the resident's assessed needs and abilities and family interviewed advised satisfaction with the activities programme. Medications are stored securely. Staff receive training in medication management and have current competencies. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.

A current building warrant of fitness is displayed in each facility. Golden Age has a rest home facility and two dementia facilities. Each bedroom in the rest home has full ensuite bathrooms. The dementia facilities rooms are either full ensuite or shared bathrooms. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area and small seating areas throughout the facility. Furniture is appropriate to the setting and arranged in such a way that allows residents to

mobilise safely. A designated laundry includes storage of cleaning and laundry chemicals. Chemicals and cleaning trolleys are stored securely when not in use. The service has implemented policies and procedures for civil defence and other emergencies. Communal 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. External garden areas are available with suitable pathways, seating and shade provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraint minimisation is practiced and overseen by the clinical manager for GHG. There are no residents using enablers or restraints.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The GHG clinical manager is the infection control coordinator with support from the registered nurses. There is a

suite of infection control policies and guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated. Benchmarking of data occurs.

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	41	0	4	0	0	0
Criteria	0	89	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Twelve caregivers (three rest home and nine dementia) were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. This was confirmed on interview with seven rest home residents and nine relatives (four dementia and five rest home). There are posters of the Code of Rights on display in the reception area of each facility and leaflets are available.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and	FA	Informed consent, advanced directives and medical care guidance instructions were recorded, as evidenced in eleven resident files reviewed (five rest home and six dementia). Dementia residents have an activated enduring power of attorney in place (EPOA). There was evidence that family involvement occurs with the consent of the resident. Family/EPOA interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives meetings (minutes sighted). 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	Interview with residents and relatives confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community as appropriate.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy guides practice and aligns with Right 10 of the Code. The managers of each facility lead the investigation of concerns/complaints for their units. Complaints forms are visible and available for relatives. A complaints procedure is provided within the information pack at entry. The managers also document verbal complaints and these are managed as per written complaints. The clinical manager for GHG conducts investigations around complaints that involve resident cares. The complaints register is up to date. All complaints to date have been responded to and managed appropriately with letters of acknowledgement, investigations, staff meetings, memos and letters of response and outcomes to complainants. Management operate an “open door” policy.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	On entry to the service, residents and family receive an information pack that includes information on how to make a complaint, Code of Rights, advocacy and Health & Disability (HDC) Commission pamphlets. Information includes dementia services and Golden Healthcare Group specific information. Relatives and residents are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Residents and family members interviewed confirmed they received all the relevant information during admission.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Family interviewed confirmed staff respect their privacy and support residents in making choices where able. Staff have completed education around privacy and dignity.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has a Māori health plan and a cultural safety policy in place. Residents who identify as Māori have this recorded on file with an individual health care plan tailored to meet Māori cultural requirements. Linkages with Māori community groups are available and accessed as required.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents needs are being met. Discussion with family confirm values and beliefs are considered. Residents are supported to attend church services of their choice if appropriate.
Standard 1.1.7:	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are

Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		included in the staff files sampled. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals practise within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the care staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies and procedures in place that meet the Health and Disability sector standards. Staff are made aware of reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff report the facility managers and registered nurses are approachable and supportive. The registered nurses have access to external training. Discussions with residents and family were positive about the care they receive. There is an open disclosure policy, which describes ways that information is provided to residents and families. There is an admission welcome pack that gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau on entry to the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The facility managers confirm family are kept informed. Relatives stated they are notified promptly of any incidents/accidents as evidenced in the sample of incident reports reviewed. Families receive newsletters that keep them informed on facility matters and events. Resident/family meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Golden Age Rest Home Limited provides rest home and dementia level care for up to 133 residents. There were 118 residents - 47 in the rest home facility (Golden Age Rest Home), 35 in Camelia Court dementia facility and 36 in the Albarosa dementia facility. There was one rest home respite resident. All residents are under the ARCC agreement. There is a facility manager in each facility and all are experienced in aged care and management. The Golden Age Rest Home facility manager has been in the position for 10 years, Camellia Court facility manager has been in the role for six years and Albarosa facility manager for five years. The service is part of the Golden Healthcare Group (GHG), which operates seven facilities in Christchurch. The GHG organisation has a corporate services manager, human resource & compliance manager and an operations manager, who report to the owner/managing director of all the GHG facilities. The organisation employs a quality assurance manager and a clinical manager.

		They both work across all facilities and provide support to the facility managers and registered nurses. Golden Age Rest Home Limited has comprehensive quality and risk management systems implemented across its facilities. There is an overall GHG group strategic plan for 2016 - 2021 that includes development of new facilities, external audits, provision of a comprehensive range of services and occupancy. The GHG quality and risk management programme for 2016 includes a quality programme for Golden Age Rest Home Limited with clearly defined goals and objectives. Additional quality improvement projects have been developed and are being implemented. Annual reviews are conducted of the quality and risk programme, last conducted in January 2016. Across GHG, benchmarking groups are established for facilities with similar service levels. Benchmarking of key clinical quality and incident data is conducted. The facility managers have all completed at least eight hours of professional development.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the temporary absence of a facility manager, the operations manager or relief manager provides cover with the support from the other facility managers, clinical manager, corporate services manager, human resource & compliance manager, quality assurance manager and registered nurses.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Golden Age Rest Home Limited is implementing a quality and risk management system. The quality programme is reviewed at each quality and risk management facility meeting. The organisation also holds bi-monthly quality and risk management meetings where the organisational goals and plans are reviewed. Goals and objectives for 2015 have been completed and data collated against the other GHG homes. Golden Age Rest Home Limited has achieved the goals for the previous year. Goals for 2016 have been documented. The GHG group have a documented mission statement, vision and values and a strategic plan for 2016 - 2021. The performance of the organisation continues to be monitored through the annual audit plan, policy and procedure review, family surveys, resident/family meetings, staff meetings, incident/accident review, complaints management, risk management surveying, the quality management programme, staff appraisals and orientation and the quality and risk management plan. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability

		Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the interRAI assessment tool. Bi-monthly staff, quality and risk management meeting minutes sighted evidence staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons, trends and graphs are displayed for staff information. The registered nurse and caregivers interviewed were aware of quality data results, trends and corrective actions. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. An internal audit programme covers all aspects of the service. Any areas for improvement are identified and implemented. A monthly summary of internal audit outcomes are provided to the staff meetings for discussion. Corrective actions are developed, implemented and signed off by the quality assurance manager. Reviews and audits are conducted more frequently where issues are identified. There is an implemented health and safety and risk management system in place including policies to guide practice. The facility managers are responsible for non-clinical accident/incident investigations. There are current hazard registers. Staff confirmed they are kept informed on health and safety matters at staff meetings. Annual resident and relative surveys are conducted with good results achieved for Golden Age in November 2016 and Camellia Court/Albarosa in February 2016. Results have been collated and results fed back to participants and staff as evidenced in meeting minutes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Twenty-seven accident/incident forms for the month of April 2016 were sampled across all three facilities. There has been RN notification and clinical assessment completed within a timely manner in the sample of reports reviewed. Accidents/incidents were also recorded in the resident progress notes. The service reports aggregated figures to the staff meeting and the quality and risk management meeting. Staff interviewed confirmed incident and accident data are discussed at the staff meeting and information and graphs are made available. Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human	FA	There are human resources policies to support recruitment practices. Ten staff files sampled (two facility managers, two registered nurses, one cook, one diversional therapist and four caregivers) contained all relevant

Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		employment documentation. Current practising certificates were sighted for the registered nurses and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that new staff were adequately orientated to the service on employment. An education planner covers compulsory education requirements over a two-year period. The RN's have completed interRAI training. Clinical staff complete competencies relevant to their role. There are 34 caregivers employed across the dementia facilities. Thirty have completed the required dementia unit standards and four are in the process of completion. All four have been employed for less than 12 months.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. Care staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family members interviewed advised that they felt there were sufficient staffing. The service has a staffing levels policy implemented, which determines that there is a registered nurse on duty or on call at all times and that at least one staff member on duty will hold a current first aid qualification. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Advised that the roster is able to be changed in response to resident acuity. Caregivers are employed across all three shifts -with two rostered on overnight in each unit. There is an RN employed for 40 hours per week in each unit. Golden Healthcare Group registered nurses provide on-call cover to Albarosa, Camellia Court and Golden Age facilities with support from the clinical manager and the facility managers. Diversional therapists provide the activities programme in the rest home and dementia facilities. The service employs cleaners, laundry staff and kitchen staff including cooks and kitchen hands. The facility managers each work 40 hours per week.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information are kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse. Staff designation was not always recorded. All files were integrated.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents are assessed prior to entry to the service by the needs assessment team and an initial assessment was completed on admission. The service has specific information available for residents/families/EPOA at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The resident's admission agreement evidenced resident and/or family and facility representative sign off. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The emergency policy outlines the procedures around transferring and what has to occur, depending on the reason for transfer. The facility managers are consulted prior to any resident transfer. The transfer/discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer and copies of documentation were forwarded with the resident. All admissions are reviewed during the weekly clinical meetings.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	The service uses individualised medication blister packs. On interview, the RN's reported that prescribed medications are delivered to the facility and are checked in on delivery. Medications and associated documentation were stored securely. A registered nurse and medication competent caregiver were observed administering medications correctly. The medication fridge temperatures are recorded. Resident photos and documented allergies or nil known were on all 22 medication charts reviewed. An annual medication administration competency is completed for all staff administrating medications and medication training had been conducted. There is a self-medicating resident's policy and procedure in place, however there are no residents competent to self-administer medications. Medications are reviewed three monthly with medical reviews by the attending GP. Individually prescribed resident medication charts were not in use for all residents. Medication charts provide a record of medication administration information. Signing sheets were fully completed. Medication charts with 'as required' medication charted recorded indications for use. 'As required' medication is reviewed by a registered nurse each time prior to administration. One respite resident did not have a signed medication chart while at the facility.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site in two kitchens. One large kitchen provides meals to rest home and retirement village residents. The other kitchen is located between the two dementia facilities and services both units. A five weekly winter and summer menu has been reviewed by a dietitian in March 2016. Food is stored appropriately in both kitchens and pantries and is labelled and dated. The fridge, freezer and hot food temperatures were being recorded. The service employs cooks who have relevant food safety qualifications. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses or facility managers. Staff were observed assisting residents with their meals and drinks. Diets are modified as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Four files (three dementia and one rest home) were reviewed of residents with weight loss. All four included interventions to manage weight loss. The care plans identify all interventions for weight management. Family meetings and the next of kin surveys allow for the opportunity for feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. The kitchen service stated that residents often give verbal feedback.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining service entry to residents to the service is recorded on the declined entry form and when this has occurred, the service stated it had communicated to the resident/family/EPOA and the appropriate referrer. Advised by the registered nurses that residents would be declined if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with an interRAI assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission that formed the basis of resident goals and objectives. Files reviewed identified assessments have been reviewed at least six monthly. The registered nurses (RN) have completed interRAI training and the assessment tool was evident in resident files (link 1.3.3.3). The resident files evidenced discharge/transfer information from the DHB (where required). Residents with dementia have a behaviour assessment completed.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident files include all required documentation. The long-term care plan records the resident's problem/need and objectives. Long-term care plans reviewed across the rest home and dementia units identified that interventions documented supported current resident needs. Short-term care plans are in use for short term needs and changes in health status. Regular GP care is implemented, as sighted in current GP progress reports and confirmed at GP interviews. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Families interviewed confirmed their involvement in the care planning process. Residents with dementia have a behaviour management plan in place, which includes triggers, diversional therapies and behaviour management strategies. These cover a 24-hour period.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans are current and interventions reflect all of the assessments conducted (with exceptions link 1.3.8.2). Interviews with staff (registered nurses and caregivers) and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and treatment rooms in each facility were stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management and documented continence products identified for day use, night use and other management. The GP documentation and records were current. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for twenty residents, four of whom had more than one wound. The RN's interviewed advised that they have access to external wound specialists as required. Progress notes and observations charts are maintained. Staff confirmed they were familiar with the current interventions of the residents they were allocated.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The diversional therapy team plans for the provision of the activities programme over seven days each week. Two diversional therapists have completed the level four diversional therapy course and have completed the dementia unit standards. One activities coordinator has commenced the diversional therapy training. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day were displayed on noticeboards around the facility. The activities plans reviewed had been evaluated at the same time as the care plans in resident's files sampled. A 24-hour diversional therapy plan has been developed for each individual resident based on assessed needs. Residents are encouraged to join in on activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used at least weekly for each facility for resident outings. The outings include visits to community functions. Residents were observed being encouraged and participating in activities on the days of audit. Family meetings and the next of kin survey provide a forum for feedback relating to activities as well as resident verbal feedback. Family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. There are specific activities programmes in place for each of the dementia units and the

		rest home. The dementia unit programmes are relevant to residents with cognitive and behavioural deficits and cater to individual resident needs. Each unit has its own diversional therapist.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Where care plan evaluations have been completed, a reassessment of the interRAI assessment tool has been completed and reflects the needs of the resident. Long-term care plans reviewed were updated as changes were noted in care requirements. Not all six monthly care plan evaluations recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan reviewed were dated and signed. Care staff document progress notes on every shift. There is evidence of GP contact when a resident's condition changes. There was recorded evidence of additional input from professionals, specialists or multidisciplinary sources.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/EPOA are involved as appropriate when referral to another service occurs. Family communication sheets confirmed family involvement.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	Policies and procedures are 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. Laundry and sluice rooms are locked when not in use. 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 management principles and practices.

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service includes a two-storey rest home complex and two dementia facilities. Each facility is connected by internal corridors. The entire service displays a current building warrant of fitness, which expires on 1 July 2016. The Golden Age rest home has 52 rooms – two of which are double rooms. All have full ensuite bathrooms. The Camelia Court dementia facility has 39 rooms with a mixture of full and shared ensuite bathrooms. Albarosa dementia facility has 40 rooms (two separate 20-bed units) with a mixture of full and shared ensuite bathrooms. Hot water temperature checks are conducted monthly in each facility. Hot water has been maintained at 45 degrees to resident areas. Medical equipment has been checked and calibrated. Testing and tagging of electrical equipment has been conducted. Each unit has a dining room and lounge area as well as smaller setting areas for residents and families to access. There are sufficient communal toilets adjacent to the lounge and dining areas. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. Courtyards are well maintained with safe paving, outdoor shaded seating, lawn and gardens. The dementia unit residents can access secure outdoor areas. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident's care plans.
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	Resident rooms in the rest home have full ensuite facilities. Dementia facilities have a mixture of shared and communal bathroom facilities. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings, floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs.

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 rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Bedrooms are personalised.
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	There are large lounge and dining rooms and small seating areas in each facility that are used for activities, recreation and dining activities. The dining rooms are spacious and located directly off the kitchen/servery areas. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. The Albarosa dementia unit is divided into two separate wings of twenty beds each. Each wing has a dining room and a lounge and is staffed separately. Each wing has its own outdoor courtyard area. There is a locked door between each wing. They combine for some activities e.g. entertainment. The Camelia Court dementia unit is a thirty-nine bed unit and has three lounges and one large dining room plus another sitting room and two outdoor secure courtyard gardens.
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	There are documented systems for monitoring the effectiveness and compliance with the service's policies and procedures. There is a separate laundry area where all personal clothing is laundered by the care staff. Larger laundry items such as towels and sheets are processed off-site by a contracted company. Staff attends infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's data safety charts are available for reference if needed in an emergency. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility.
Standard 1.4.7:	FA	The service has a fire and emergency procedures manual. Each facility has an approved New Zealand Fire

Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.		Service evacuation scheme. Fire drills are conducted six monthly. There is a trained person with a first aid certificate on each shift in each facility. Fire safety training has been provided. There is a call bell system in place. A civil defence kit is stocked and checked. Water is stored and sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conducts checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All resident bedrooms have external windows with plenty of natural sunlight. The facility is heated and windows open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Family interviewed state the environment is comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Golden Age has an established infection control (IC) programme that is part of the GHG infection control programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The clinical manager for GHG is the designated infection control nurse with support from the registered nurse, care staff and the GHG quality and risk management team. The IC team at Golden Age is part of the quality and risk team meetings who review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme	FA	There are adequate resources to implement the infection control programme at Golden Age. The infection control (IC) nurse has maintained practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		and wall mounted alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The facility is committed to the ongoing education of staff and residents. Education is facilitated by the GHG infection control nurse with support from the registered nurses. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2015.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The GHG infection control nurse collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs with support from the GHG quality assurance manager. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly and annually at facility and organisational level. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. An outbreak in November 2015 in the dementia units was appropriately managed with notification made, extra resources provided, appropriate management of staff, residents and families and a debriefing post incident.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by the clinical manager for GHG. There are currently no residents requiring restraint and no enablers.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Eleven files were reviewed including progress notes and care plans. Entries in progress notes are written by caregivers and registered nurses. Regular RN input was evident in progress notes. The designation of the staff member making the entry was not evident in all files reviewed.	Progress notes in the resident files reviewed did not consistently record the staff member's full name and designation.	Ensure that all records and resident file entries record the staff members name and designation. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,	PA Low	The signing sheets for regular and 'as required' medications corresponded with the instructions on the medication chart. 'As required' medications had indications for use prescribed on the medication chart. There are no standing orders in use. The pharmacist completes a weekly stocktake of controlled drugs blister packs with the RN. Twenty-one of twenty-two medication charts reviewed evidenced prescribing that aligns with best	One respite resident did not have a signed medication chart while at the facility. The service utilised a hospital discharge letter which recorded all current medications and doses.	Ensure all residents have a signed medication chart. 60 days

review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		practice medication charting while at the facility. One respite resident did not have a signed medication chart while at the facility. The respite resident was discharged from the service on the day of audit.		
Criterion 1.3.3.3 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.	PA Low	InterRAI assessments have been completed for all residents. Initial assessments and care plans are developed for residents on admission. Long-term care plans are developed and reviewed six monthly. Short-term care plans are developed as required for wounds and changes in health conditions. Four of eleven residents had assessments and/or care plans developed in a timely manner.	(i)One rest home resident did not have an initial assessment and care plan completed within 48 hours; (ii) InterRAI assessments for two dementia residents were completed after 21 days; iii) two long-term care plans (one rest home and one dementia) were not developed within 21 days; (iv) one short-term care plan for a rest home resident with a new wound was developed one week after the event; and (v) one interRAI assessment for a dementia resident was completed after the long-term care plan was developed for one resident.	(i)Ensure that initial assessments and initial care plans are developed within 48 hours; (ii) ensure that interRAI assessments are completed within 21 days of admission; (iii) ensure that long-term care plans are completed within 21 days; (iv) ensure that short-term care plans are developed when required; and (v) ensure that interRAI assessments are completed prior to the long-term care plan. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or	PA Low	All aspects of the assessment and care planning process have been conducted as evidenced in sample of files reviewed, however not all were completed within the required timeframes (link 1.3.3.3). Care staff document in progress notes on every shift. The registered nurses write in progress notes on a regular basis. Long-term care plan evaluations reviewed have been conducted six monthly. In	Three of eight long-term rest home care plans did not have sufficient detail in the evaluation of long-term care plans.	Ensure evaluations reflect how the interventions have met the goals outlined in the long-term care plan. 90 days

intervention, and progress towards meeting the desired outcome.		the dementia resident files reviewed, evaluations described how well the interventions have met the care plan goals. Short-term care plans reviewed have been developed and reviewed as required.		

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.