

Heritage Lifecare Limited - Karina Rest Home

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 The DAA Group 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:	Heritage Lifecare Limited	
Premises audited:	Karina Lifecare	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 1 February 2017	End date: 2 February 2017
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:	35	

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

Karina Rest Home in Palmerston North is certified to provide rest home level care for 37 residents. On the day of this certification audit there were 35 residents. This consisted of 31 rest home residents and four younger people with a disability.

This certification audit against the Health and Disability Services Standards and the provider's contract with the district health board (DHB), included observation of the environment, interviews with a director, the management team and staff, review of documentation and interviews with residents and their families and a general practitioner. There were no areas that required improvements.

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 Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.


Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. The manager maintains a current register.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation has a documented business and strategic plan in place which is reviewed regularly. The governing body is Heritage Lifecare Limited. A facility manager and business manager oversee the day to day management of the facility. They both have position descriptions and the necessary skills, knowledge and experience to perform their job. They are supported by the head office management team and regular reports flow between the two.

There is a quality and risk management system in place. This includes quality and clinical indicators, an internal audit programme and management of risks. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting

system and corrective action planning links to the quality improvement cycle to manage any risks and ensures quality improvement occurs. Data collation is managed at head office and provided to the facility in an easy to read graph and text format.

There are appropriate systems for the recruitment, appointment and management of all staff. Formal orientation and an ongoing education and training plan is provided/developed for all employees. Staff have a current performance appraisal and this process occurs annually. The business and facility managers prepare the roster based on residents' needs, and safe staffing levels and the facility manager's input. The roster includes registered nurses, caregivers, and a range of laundry, cleaning, kitchen and activities staff. The current roster is adequate for the number of residents and their level of need.

A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Coordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, within the required timeframes. Registered nurses (RNs) are on duty eight hours a day and an on call system of RNs covers each 24 hour period in the facility. RNs are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and

outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by an activities coordinator, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using the 'Medimap' system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and met food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility is an older style renovated building and well maintained for its age. Residents' rooms are kept clean, tidy, well ventilated and at a comfortable temperature. There are a number of communal areas which provide a variety of spaces for residents to use. There are enough toilets and bathrooms for the number of residents. The building has a current building warrant of fitness.

Easily accessed, safe and well maintained outside areas are provided for residents' use.

There are systems in place for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are documented and available in several places around the facility. Regular fire drills occur and staff are well trained to respond in any emergency. There is a generator available and adequate supplies for civil defence and other emergencies. Appropriate security arrangements are in place.

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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Restraint minimisation and safe practice policies and procedures are implemented. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had one resident with an enabler in the form of bedrails. There were no restraints in use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	45	0	0	0	0	0
Criteria	0	93	0	0	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>A welcome pack and letter is prepared for each incoming resident and their family/whanau. This includes the residents' code of rights policy, the complaints policy and information relating to Karina Rest Home facility.</p> <p>Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Registered nurses and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, and invasive procedures.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p>

		<p>Staff were observed to gain consent for day to day care on an ongoing basis.</p> <p>Informed consent training is provided to clinical staff annually.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family/whanau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews.</p> <p>Advocacy training is provided to all staff annually.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of 'Quality of Life', caring and living life to the highest level of independence.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whanau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy which complies with Right 10 of the Code. The facility manager and/or business manager commence initial investigation of complaints with input as required from the organisation's quality and compliance manager. Complaints forms are visible and available at the front desk. A complaints procedure is provided to residents within the information pack on entry to service. Five complaints in 2016 were included on the register. Four have been resolved to the satisfaction of the complainant. One is ongoing with documentation and actions within recommended timeframes. A family member involved in a complaint confirmed timeframes are adhered to. The complaints register was up to date.</p>
Standard 1.1.2: Consumer Rights	FA	The information, communication and language policy requires that all staff will ensure residents and

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>their families/whanau have access to comprehensive information about their facility, care planning and the care they receive.</p> <p>Information on the Code, informed consent, advance directives, resuscitation, the residents welcome pack, input into care planning, complaints/concerns, advocacy and accessing an advocate is provided and staff ensure residents understand it.</p> <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through the facility manager as part of the admission process, and from information provided and discussion with staff.</p> <p>The Code is displayed in the rest home entrance way, in front of the nurses' office and in residents' lounges. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.</p> <p>Training on advocacy is annual for all staff and included on the training plan list.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, ensuring resident information is held securely and privately, and exchanging verbal information with residents and their family/whanau. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, attending community activities, arranging their own visits to the doctor, participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. The facility manager is the privacy officer for the facility.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The Maori perspective of health guide gives information about Maori beliefs in relation to illness, the Te whare tapa wha model of health and an outline of cultural belief experiences in relation to health in the context of Aotearoa New Zealand.</p> <p>Heritage Life care has a policy on consultation for the Maori Health plan, to guide the facility on developing their plan. It includes making contact with the local DHB, Maori health providers, kaumatua and kuia at the local marae and advocacy groups, as necessary, to support residents who identify as Maori in the facility. There is a Maori health plan consultation template with questions to ask the Maori resident and their whanau so that any barriers which are within the facility's control can be identified. This also aligns with the cultural safety policy, which includes recognition of Maori values and beliefs.</p> <p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources include the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility.</p> <p>Maori residents and whanau interviewed confirmed that their health and disability needs are met in a manner that respects and acknowledges their individual and cultural values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Each resident's culture, values and beliefs are identified on admission and their preferences documented in their care plan.</p> <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents had dietary preferences and spiritual preferences documented, and interviews confirmed that staff ensure the residents' needs are met. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supports that individual needs are being met.</p> <p>There is a cultural safety policy which states that services will be delivered in a culturally safe manner to all residents, family/whanau and staff acknowledges each individuals spiritual and cultural values, beliefs and needs.</p>
<p>Standard 1.1.7: Discrimination</p>	<p>FA</p>	<p>Residents and family/whanau members interviewed stated that residents were free from any type of</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>discrimination, harassment or exploitation and felt safe. A general practitioner interviewed also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses and carers have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, occupational therapist, wound care specialist, community dieticians, a psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for internal and external education through Careerforce training and there is evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whanau members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the DHB or Older Persons Health Services when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak</p>

		English. Staff provide interpretation as and when needed and use family/whanau members, as appropriate. Communication cards are available for any potential residents for whom English is not their first language. The Information, Communication and Language policy includes the provision of interpreter services. In the first instance families/whanau will be used to interpret for the resident. If they are not available, then appropriate interpreter services will be accessed and/or information will be provided in other formats.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Heritage Lifecare Limited - Karina Rest Home is privately owned by a company. One director was interviewed during the audit. The audit and compliance manager was on-site during the audit and verified the flow of information between the facility, head office and the board. The facility manager and business manager oversee the day to day operation and both have been in their positions for a number of years. The mission, vision and values of the organisation are documented in the strategic plan and quality plan. These are reviewed annually when progress against the objectives and goals in these documents are reviewed.
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	In the absence of the facility manager (who is a RN), either of the two registered nurses assumes the role with assistance from the audit and compliance manager. Both have suitable experience for the roles. The business manager assumes the non-clinical roles and during her absence the facility manager will cover these, with the RN's taking on the clinical management tasks. At all times there is cover available from head office, should the need arise. Staff members interviewed reported that the facility manager, business manager and registered nurses are providing stability as the management team of the facility and their respective areas of responsibility. Staff reported that they are approachable with an 'open-door' philosophy. There is evidence of reporting to head office and the board at all meetings.
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	FA	There is a comprehensive quality and risk management plan specific for the facility, which is reviewed annually. The organisation's quality and compliance manager, in consultation with the facility managers, coordinates the development and review of all policies and procedures for the facility, and includes these changes as agenda items in all meetings. All documents reviewed during the audit were

<p>improvement principles.</p>		<p>current, and some were in the process of review.</p> <p>The facility manager coordinates the quality and staff committee, which meets monthly through the year. A comprehensive agenda includes the quality plan objectives, completed audits for the past month, adverse events, corrective actions, infection control and restraint minimisation, a report from health and safety committee, complaints, staff training, as well as any ongoing developments and review of documents. The separate health and safety committee meets every two months. There is an organisation wide weekly operations meeting teleconference that covers all aspects of service delivery and new developments. The two managers link into this weekly and file a written report to head office each week.</p> <p>The facility manager implements the internal audit calendar, or delegates audits to staff to complete. Those reviewed are detailed and complete with recommendations identified and implemented.</p> <p>Each month an analyses of quality data is collated by head office and graphs of the adverse events are on display in the staff room. Staff members interviewed confirmed that they receive information about the events which occur in the facility and how these are managed. They also demonstrated an understanding of their responsibilities in the quality system appropriate to their role.</p> <p>There is a risk management plan, which identifies the risks to the business and includes strategies to mitigate these. The plan is very detailed and specifies the roles and responsibilities of all staff. This is reviewed regularly at the same time as the review of the quality plan and strategic plan.</p> <p>A corrective action plan is in place for any shortfalls. Those reviewed that have been completed and were closed out.</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>The incident and accident policy includes the essential notifications and statutory and regulatory reporting, including the requirement to report pressure injuries of category 3 under section 31 of the Health and Disability Services (Safety) Act. At interview, the facility manager demonstrated clearly her responsibility in this area and explained the process, for example, for pressure injury reporting.</p> <p>Adverse events are reported and recorded on appropriate event reporting forms. The data from collated adverse events is summarised by the facility monthly and reported at meetings and in graph form on the staff room notice board. A weekly report is sent to head office. Staff confirmed that they report events using the reporting forms, or verbally to the facility manager. They understand the importance of reporting and recording events.</p> <p>General practitioners (GPs) are notified of adverse events when they occur and this was confirmed during interview with one GP who visits the service and when reviewing event forms. Residents and family members reported that they are also notified of events and appreciate receiving this</p>

		information.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures for recruitment, appointment and management of staff reflect current legislation and good employment practice. All recruitment is managed by the facility manager with the assistance of the business manager if required. Both were interviewed during the audit. All appropriate checks are undertaken during the appointment process and this was confirmed during a review of personnel files. Professional qualifications are verified and monitored annually. Records reviewed verify current practising certificates / professional registrations for registered nurses, medical practitioners and allied health professionals. Personnel files reviewed confirmed that performance appraisals are also current.</p> <p>A comprehensive training and education programme is available for all staff. This includes an orientation and induction programme and ongoing annual training. The facility and business managers maintain a training register, which includes essential training, competencies, and other in-service and external training attended by staff. The programme includes wound and pressure injury management.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing policy is in place to alter staffing according to the skill mix and resident's needs. Rosters are the responsibility of the business manager with oversight by the facility manager. Three weeks of non-consecutive rosters reviewed verified adequate care staff on every shift throughout the facility and across all shifts over 24 hours and seven days a week.</p> <p>There are two cooks, two kitchen hands, and a separate cleaner, who also is the maintenance person. One full time activities person five days a week provides oversight of activity plans and programmes. The facility manager and registered nurses share on call. The current staffing levels meet the requirements of residents.</p> <p>Residents, family, staff and the GP interviewed reported that there are sufficient numbers of suitably skilled staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. Residents'</p>

when required.		<p>files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Training is provided to the administration and clinical staff annually on documentation requirements.</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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whanau are encouraged to visit the facility prior to admission and meet with facility manager (FM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updates information from NASC and the GPs for residents accessing respite care.</p> <p>Family/whanau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>The screening/entry to service process is to determine any potential risks involved in the provision of services.</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>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'pink envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts (where applicable), and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family/whanau members of the resident reported being kept well informed during the transfers of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using 'Medimap' and a robotics system was observed on</p>

<p>safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. There are no standing orders and verbal orders rarely occur but processes are in place to enable safe administration and appropriate documentation.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted on Medimap, including allergies and intolerances, dates recorded on the commencement and discontinuation of medicines, and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medication chart.</p> <p>There was one resident who self-administered medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the facility manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>All staff who are involved in medication administration have annual training and competency assessments.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by the kitchen manager and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food</p>

		<p>handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, satisfaction surveys and resident meeting minutes. Residents were observed to be given sufficient time to eat their meal and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and family/whanau. Examples of this occurring were discussed with the Clinical Manager. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> <p>Any decision to decline entry to the facility is covered in the resident screening and selection policy. When declining entry, a meeting is arranged with the resident and or their family/whanau or advocate. The decision to decline entry is to be conveyed in a compassionate manner and where appropriate other options for residential care will be provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Each resident has a care plan and life style plan. If needed the short term care plan is used.</p> <p>Information is documented using validated nursing assessment tools, such as a pain assessment, Norton scale risk assessment, skin integrity, Coombes falls assessment, continence assessment, nutritional assessment and profile, oral assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents' files reviewed during the audit had a current interRAI assessment.</p> <p>There were a range of other tools/recording forms in use such as fluid balance charts, weight loss recording tool, bowel management tool, deterioration in health record and catheter change form.</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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidenced service integration with progress notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families/whanau reported participation in the development and ongoing evaluation of care plans.</p> <p>The Guidelines for writing documents states that residents will have a care plan developed within 24 hours of admission (see standard 1.3.4 for assessment tools). An individual lifestyle plan is developed within three weeks of admission.</p> <p>Short term care plans are developed in response to specific problems and kept on the resident's file for as long as needed. If the problem continues, it is included in the long term care plan. The guidelines documents include frequency of reviews (See standard 1.3.8).</p> <p>Clinical staff have annual training in care planning.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at Karina Rest Home. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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>	<p>FA</p>	<p>The activities programme is provided by an activities co-ordinator who has commenced the Careerforce training.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review.</p> <p>The planned weekly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered and the</p>

		<p>younger residents have activities available to meet their specific needs. Examples included music and singing, planned outings, individual outings, volunteers coming to read to residents, and children's groups coming to visit.</p> <p>The activities programme is discussed at the minuted residents' meeting and indicated residents' input is sought and responded to. Resident and family/whanau satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme encourages them to reach their highest level of independence within the limitations they have.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans consistently being reviewed included those for urinary tracts infections (UTIs), falls, infections, any changes in the resident's normal status. Progress was evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own GP. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, needs assessor, podiatrist, wound care specialist, geriatrician, and older persons' mental health service. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of</p>	FA	<p>There are policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and</p>

<p>Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>handling of chemicals. Waste is appropriately managed. All chemicals sighted were stored securely. Staff interviewed demonstrated knowledge of handling chemicals and were observed using personal protective equipment.</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 current building warrant of fitness expires 20 January 2018. There have been no changes to the building since the previous audit.</p> <p>Residents and family members interviewed during this audit reported that they find the environment is maintained to a high standard at all times and it is well presented.</p> <p>There is a regular system for preventative maintenance, relevant electrical safety testing, and calibration of equipment. This was maintained and current. All hazards have been identified in the hazard register.</p> <p>Outside areas were easily accessed from the facility and were well maintained.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Nine residents' rooms have full ensuites. The remaining residents' rooms have hand-washing facilities with soap dispensers and paper towels. There are sufficient showers and toilets for residents. Separate visitor and staff toilets are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents' rooms are spacious enough to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur and equipment can be transferred between rooms. Mobility aids can be managed in communal rooms.</p> <p>Rooms were observed to be personalised with furnishings, photos and other items and the service encourages residents to bring in personal items.</p> <p>There was room to store mobility aids such as walking frames safely.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has several communal lounge/dining areas. There are smaller seating areas for residents and families within the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed verify that the facility has sufficient space and residents may stay in their own areas or use any of the communal lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is completed on site in a large laundry. A survey of residents and family confirmed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. All chemicals sighted were labelled. Material safety datasheets are displayed and a copy held on the cleaning trolleys. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is at least one staff member on duty at all times with a first aid certificate. Emergency plans are accessible to staff and includes management of all potential emergency situations. The organisation has policies and procedures for civil defence and other emergencies. There are enough supplies available, such as dressing and first aid equipment. There is an approved evacuation plan for the facility. Fire evacuation training and drills are conducted six monthly.</p> <p>Emergency equipment, water and food are available in a separate area and routinely checked.</p> <p>Appropriate security systems are in place. The call system functions throughout and when activated is responded to promptly. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out.</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</p>	FA	<p>Residents' rooms are provided with adequate natural light, ventilation, and in an environment that is maintained at a safe and comfortable temperature. Temperatures are routinely monitored.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical co-ordinator/infection prevention and control officer (IPC). The infection control programme and manual are reviewed annually.</p> <p>The facility manager/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality/risk committee meeting. This committee includes the owners/directors, facility manager/IPC coordinator, and the health and safety officer.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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 prevention and control (IPC) coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since 2014. She has undertaken IPC training and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control nurse specialist and Older Persons Health Services are available for advice. Expert advice from the laboratory is also available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility.</p>

<p>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>		<p>Staff interviewed verified knowledge of infection control policies and practices.</p> <p>The policies and procedures include definitions of infections and an identification of infections form. There is a notifiable diseases list. Surveillance of infections is also conducted.</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>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Infection prevention and control is included in the education programme. Staff receive annual training.</p> <p>When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred in 2015 when there was a norovirus outbreak in the facility affecting residents and staff.</p> <p>Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during the norovirus outbreak. Families/whanau confirmed they also were given education by staff during the outbreak.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident's clinical record, infection reporting form, and resident management system. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager, and head office.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies and procedures for the use of restraints and enablers which comply with the standard. All alternatives to restraints are considered and used before any restraint is used.</p> <p>On the days of audit there were no restraints in use and one resident with an enabler. The enabler used was a bedrail. The restraint coordinator is the facility manager and was interviewed in relation to this standard. She has attended all training provided at the facility. She demonstrated her understanding of restraint and enabler procedures.</p> <p>Enablers are approved, monitored and reviewed. The resident's file of the person using an enabler was reviewed and all documentation was current and as described in the organisation's policies and procedures.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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.