

Komal Holdings Limited - Homestead Ilam Home and Hospital

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Komal Holdings Limited
Premises audited:	Homestead Ilam Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 February 2017 End date: 1 March 2017
Proposed changes to current services (if any):	This audit has assessed the service as suitable to provide hospital (medical) level of care.
Total beds occupied across all premises included in the audit on the first day of the audit:	36

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.

General overview of the audit

Homestead Ilam is certified to provide rest home and hospital (geriatric) level care for up to 40 residents. On the day of the audit there were 36 residents. This audit also included verifying the service is suitable to provide hospital (medical) level of care.

The current owners (the nurse manager and general manager) are supported by a clinical coordinator and a quality coordinator. Residents and family interviewed were complimentary of the service they receive.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. The prospective owner was interviewed by telephone prior to the commencement of the audit.

The prospective owner currently owns an aged care facility in North Canterbury and has been actively managing this service (rest home level of care). The prospective owner will be taking on an owner/operator role and will be supported by an experienced aged care consultant. There will be a transition period between owners of four to six weeks as confirmed by the nurse manager and the prospective owner. It is intended that policies and procedures will be customised to the site by the aged care consultant. Staffing will remain the same and a clinical manager is yet to be employed.

This audit identified that improvement is required around the appointment of a clinical manager, medication documentation and significant repairs to the building from the 2011 earthquake.

Consumer rights

Homestead Ilam provides care in a way that focuses on the individual resident. The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. The new owner is familiar with and has had training around the Code. Residents and family interviewed verified ongoing involvement with community.

Organisational management

Homestead Ilam is implementing a quality and risk management system that supports the provision of clinical care. Policies and procedures meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints and internal audits. The health and safety programme meets current legislative requirements. There are human resources policies including recruitment, job descriptions, selection and orientation. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an annual education/training schedule. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Entry to the service is managed primarily by the nurse manager and registered nurses (RN) (including the clinical coordinator). There is comprehensive service information available. Assessments, care plans and evaluations are completed by the registered nurses within the required timeframes. Care plans are written in a way that enables all staff to clearly follow their instructions. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options can be provided. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

The building has a current warrant of fitness. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge areas throughout the facility in addition to the main communal areas. The internal areas can be ventilated and heated. The outdoor areas are safe and easily accessible and enjoyed by residents. Cleaning and laundry staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit no residents were using restraints and three residents were using an enabler.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. Relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	42	0	3	0	0	0
Criteria	0	90	0	3	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>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. Staff interviewed (one registered nurse (RN), the nurse manager (RN), the quality coordinator (RN), the clinical coordinator (RN), three carers and one diversional therapist) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service and in regular in-service training.</p> <p>Interview with the prospective owners confirmed their understanding of the consumer rights and their obligations to ensure the Code of Health and Disability Services Consumers' Rights and the Nationwide Health and Disability Advocacy Service information is clearly displayed and easily accessible to anyone to whom the information is relevant.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents including photographs were obtained on admission and sighted in six of six resident files reviewed</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>(three rest home and three hospital). Advance directives were sighted in each residents file relating to resuscitation status, having been completed by the resident (where they were competent to do so) in the presence of the general practitioner, or by the GP where the resident was not competent and a clinically indicated order is deemed appropriate.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The carers and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>Six of six admission agreements reviewed had been signed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Nationwide Health and Disability Advocacy Service brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The nurse manager leads the investigation of any concerns/complaints. Complaints forms are visible throughout the facility. A complaints procedure is provided to residents within the</p>

		information pack at entry. A complaints register is maintained. The five complaints received in 2016 were reviewed and appropriate action had been taken within the required timeframes and to the satisfaction of the complainant for all complaints. Corrective actions were implemented and followed up. Residents and families interviewed are aware of the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The nurse manager or an RN discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. Eight residents (four rest home and four hospital) and three family members interviewed (all hospital) reported that the residents' rights were being upheld by the service.
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	The residents' personal belongings are used to decorate their rooms. Three carers interviewed reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy.
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 is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. The service has access to a cultural advisor when this is required.
Standard 1.1.6: Recognition And Respect Of The Individual's	FA	The service identifies the residents' personal needs, culture, values and

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>beliefs at the time of admission. This is achieved in collaboration with the resident, family/whānau and/or their representative. Beliefs and values were incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the carers confirmed their understanding of professional boundaries including the boundaries of the carers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility fortnightly or more often if required. Resident/family meetings are held monthly and are led by the administrator. Residents and family/whānau interviewed reported that they are satisfied with the services received. A resident satisfaction survey is completed annually. The prospective owners stated that they will continue with best practice at Homestead Ilam.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Ten incident forms reviewed for January 2017 identified family were notified following a resident incident. The nurse manager and RNs confirmed family are kept informed. Family members interviewed confirmed they are notified of any incidents/accidents, changes in health or significant events. Families receive regular newsletters and are invited to attend the resident/family meetings.</p>
<p>Standard 1.2.1: Governance</p>	<p>PA Low</p>	<p>Homestead Ilam provides care for up to 40 rest home and hospital level</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>residents. All except two beds (which are rest home only) are dual-purpose. On the days of audit there were 40 residents. Sixteen residents were receiving rest home level care (including two on short-term respite contracts and twenty were receiving hospital level care. All except the two short-term respite residents were on the age-related care contract (ARCC).</p> <p>The facility is currently being managed by the owner; one as the nurse manager (a registered nurse) and the other as the general manager. The nurse manager is on site at least 40 hours per week and the general manager has slightly more flexible hours but is on site most days. She is supported by a clinical coordinator who works 40 hours per week and a quality coordinator. The nurse manager has completed at least eight hours of professional development around the management of a hospital facility in 2016.</p> <p>The prospective owner currently owns an aged care facility in North Canterbury and has been actively managing this service (rest home level of care). She has completed more than eight hours training relating to the management of a hospital or rest home facility in 2016. The prospective owner reported that a manager has been appointed to the facility she currently owns and manages. This will then allow her to be on site as full time manager at Homestead Ilam. She is aware of the need to appoint a clinical manager and informal negotiations have begun but the appointment is not yet confirmed. There will be a transition period between owners of four to six weeks as confirmed by the nurse manager and the prospective owner.</p> <p>The prospective owner has clearly documented the purpose, values, scope, direction, and goals of the organisation and ensure that the purpose, values, scope, direction and goals will be regularly reviewed. The prospective owner will be taking on an owner/operator role and will be supported by an experienced aged care consultant with who she has an existing professional relationship. A position description for the prospective owner/manager has been developed and includes that the manager will be on site 40 hours per week and on call, and all appropriate requirements for the service including efficient and effective management of the day-to-day operation of the service and the provision of timely, appropriate and safe services to residents. The tentative settlement date is 1 April 2017. Relevant authorities have been notified</p>
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		of pending change of ownership.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager will provide a temporary management role in the event of the owner/manager being away (confirmed in interview with the prospective owner).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Homestead Ilam has a quality and risk programme that is being implemented and includes specific quality goals for 2017, for example, around service delivery and staff management.</p> <p>Policies and procedures are maintained by the quality coordinator and they align with current good practice and meet legislative requirements. Staff confirmed they are made aware of any new/reviewed policies. There are two monthly quality meetings and a range of quality and department reports including infections, accidents and incidents, health and safety, concerns/complaints and internal audits were reflected as discussed in meeting minutes. All staff are invited to the quality meetings and the meeting minutes are made available and identified quality data as being discussed. A variety of graphs and comparisons are provided to staff regularly.</p> <p>Areas for quality improvement are identified via staff queries, issues that arise or topical/current events and a focus board in the nurses' station provides a variety of information and targets around the issue. This approach has led to positive results including a reduction in the number of falls over 2016.</p> <p>There is an internal audit programme that covers all aspects of the service including environmental, food service, cleaning service, resident care and documentation. Corrective actions for partial compliance had been developed, implemented and signed off by the quality coordinator or nurse manager. A family/resident survey in October 2016 showed a high level of satisfaction with the service. The survey identified a deficit in understanding of complaint information. The corrective action plan included that the information is to be addressed again at first care plan review, as so much information is provided at admission time. Resident meetings are two monthly and provide residents with a forum for</p>

		<p>feedback on the services.</p> <p>A health and safety committee has been formed and the three representatives have completed external training, including transitional training following the legislative changes in 2016. Health and safety is discussed in all quality meetings and there is a staff health and safety award every two months to encourage staff engagement. The service has a health and safety focus month each June. There is a falls prevention and management policy in place and falls are addressed on an individual basis as part of the care planning process and in a wider level as part of the continuous improvement process and meeting quality goals.</p> <p>Interview with the prospective owner confirmed the intention to contract the aged care quality consultant they use at their existing facility. They intend using policies and procedures customised to the site by the consultant (a consulting registered nurse and qualified/experienced auditor).</p> <p>They intend to utilise the online benchmarking and quality/risk programme developed by the contractor to track management of adverse events, complaints, infections, record restraint/enablers (and their reviews) along with conducting internal audits online. The change of documentation will be transitioned and implemented as new admissions occur and at the time six monthly InterRAI reassessments and care plan reviews/evaluations are due.</p> <p>Staff will be orientated to the new system from the commencement of their employment for new staff and through an education programme for existing staff.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Incident forms are managed using an electronic database. Ten accident/incident forms for January 2017 were reviewed. All document timely RN review and follow-up. There is documented evidence the family had been notified of incidents/accidents. The service collects incident and accident data and analyses falls according to time and location of fall. Monthly collation includes graphs and trend analysis.</p>

		Discussions with the nurse manager and the prospective owner confirmed both have an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Seven staff files sampled (the clinical coordinator, one RN, two carers, one cook, one household staff member and the diversional therapist) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the RNs. Three of the nine registered nurses have completed InterRAI training.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Staff complete competencies relevant to their role such as medications, restraint, infection control and syringe driver competencies (for registered nurses through the hospice). There is an education planner in place that covers compulsory education requirements over a two-year period.</p> <p>This includes annual training days that are repeated to ensure all staff attend and ongoing in-service topics during the year. In addition, the feature board has education topics for residents and staff that are topical. An example was that the board featured information about dental care at the time of the audit following a resident experiencing a dental abscess. Hydration was a recent topic following recent media interest in the quality of water in Canterbury. Residents are invited to attend relevant training sessions alongside staff. Registered nurses attend DHB and hospice external training, including appropriate training to provide hospital (medical) level of care.</p>
Standard 1.2.8: Service Provider Availability	FA	The service has a documented rationale for determining staffing levels

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The nurse manager works on site Monday to Friday and is supported by the clinical coordinator who works Monday to Friday and the quality coordinator (who makes up to full-time with working as a registered nurse on the floor). In addition to the nurse manager, clinical coordinator and designated quality coordinator hours there is a registered nurse on duty 24-hours per day. The residents interviewed informed there are sufficient staff on duty at all times. The rosters sighted confirmed that staff are replaced on the roster.</p> <p>The prospective owner stated in the interview that apart from the change in management and clinical management roles (link 1.2.1.1) there is no intention for them to make any changes to staffing and all staff transfer over to the new owners on the date of settlement. The prospective owner will be taking on the day-to-day management, organisational management and governance of the facility from the current owner/manager. She has experience managing staff in aged care (although not hospital level), including staff skill mix and contractual obligations. The prospective owners will also be available to the staff 24-hours, seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.</p>
<p>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.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in resident's records. Relatives interviewed stated they were well-informed upon admission. The admission agreement reviewed reflects the current ARC contract. Files sampled demonstrated that admission agreements were signed. Exclusions from the service are included in the admission agreement.</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>	<p>FA</p>	<p>Policies describe guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The facility has a comprehensive policy for medication management including self-administration of medication. Medication is securely stored and expired medication securely disposed of correctly. Medications are checked on delivery against the medication chart. Medication errors are reported and annual medication audits completed. Medication trolley, fridge and cupboard stock contents were all within expiry dates. Nine of thirteen medication charts sampled had been regularly reviewed three monthly by the GP. All reviews were current at the time of the audit but prior reviews were longer than three months apart for these files. All medications and treatments were prescribed except one resident using oxygen. Every resident has a long list of standing order medications signed individually by the GP in the medication file. The standing orders did not meet requirements.</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 service employs one cook, one relieving cook and kitchen assistants for each shift; all have completed food safety certificates. The procurement of the food and management of the kitchen is overseen by the main cook. There is a well-equipped kitchen and all meals are cooked onsite. There is a separate dining room. Meals are plated from a bain-marie. On the day of the audit, meals were observed to be hot and well presented. Kitchen fridge, food, freezer and dishwasher temperatures were monitored and documented daily, these were within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets</p>

		were noted on the kitchen noticeboard. The menu is a five-week seasonal menu and has been approved by an external dietitian. Dietary supplements are available. Residents and families interviewed were complimentary of the food service, and can provide feedback through a food survey and resident and relative meetings. The nurse manager interviewed confirmed that weekly meetings with kitchen staff are held to improve on the flow of communication and part of quality improvement.
<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	The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry was declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	All long-term files sampled contained InterRAI assessments and assessment summaries. One resident was on short-term respite care and one resident was new to the service. Assessment information was detailed and gathered from a variety of sources, including the resident, their family and allied health professionals. Additional assessments for management of behaviour, pain, wound care and restraint were appropriately completed according to need.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans sampled were comprehensive and demonstrated service integration. There was evidence of service integration with documented input from a range of specialist care professionals. The goals of the care plans incorporated the Spark of Life and Eden Philosophy principles. The resident care plans sampled were resident focused with detailed interventions and management plans where required. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan.

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans sampled documented the interventions required to meet resident needs. Residents and family members reported that the care provided is of a high standard and that they are involved in the care planning. RNs interviewed state there is adequate equipment provided including continence and wound care supplies. Wound assessment forms, management plans and ongoing assessment and treatment forms were completed for two wounds and both had been reviewed within the stated timeframes. There were no complex wounds or pressure injuries. All of them have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Monitoring occurs for weight, vital signs, regular turns, food and fluid records, pain monitoring and blood glucose recordings.</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>There is one diversional therapist and one activities volunteer providing activities from Monday to Friday. On the day of audit, residents were observed being actively involved in activities. Residents and family interviewed were satisfied with the activities provided. The activities programme is comprehensive, diverse and is designed for high end and low end cognitive functions and focused on achieving individual goals. The programme is developed monthly and was displayed in large print and available to all residents. Residents have an assessment completed over the first three weeks after admission, obtaining a complete history of past and present interests, career, and family. Resident files reviewed identified that the individual activity plan was reviewed at least six monthly. The diversional therapist interviewed explained the variety of the programme and how the activities programme aims to promote the Spark of life and Eden Philosophy principles, highlighting music therapy and active community participation.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans are evaluated by a registered nurse six monthly or when changes to care occur. Files sampled demonstrated that short-term care plans were used for short-term needs and regularly evaluated. The issues were either resolved or added to the long-term care plan as an ongoing issue. A multi-disciplinary review is completed six monthly and</p>

		involves the RN, GP, activities staff and the resident/family. There is at least a three-monthly medical review by the medical practitioner. The family members and residents interviewed confirmed they are invited to attend care plan reviews and GP visits.
<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	Referral to other health and disability service professionals was evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service has access to a wide range of support through either the GP or the DHB. Input from a specialist nurse was evident in three of the resident files sampled.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are comprehensive and up-to-date policies that include chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps disposal containers are available. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.
<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>	PA Low	<p>The building holds a current warrant of fitness, which expires on 1 June 2017. An external provider checks fire equipment. Medical equipment has had the required safety and calibration checks. Electrical equipment has been tested and tagged. Preventative maintenance occurs. Earthquake repairs are required. There is an annual maintenance programme in place. Hot water temperature has been monitored monthly in resident areas and was within the acceptable range.</p> <p>The living areas and bedrooms have vinyl surfaces as do bathrooms/toilets and kitchen areas. The corridors are wide and promote safe mobility. Residents were observed moving freely around</p>

		<p>the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.</p> <p>Staff interviewed reported that all the equipment they require to meet residents' needs, including those with hospital (medical) level needs who have previously been at the facility is available and management access any required equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of toilets and showers in all areas. Resident rooms have hand basins and ensuite toilet facilities. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Communal toilets and bathrooms have appropriate signage and locks on the doors and are large enough to meet the needs of hospital level residents.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuite facilities. Bedrooms are large enough to include a lazy boy chair and extra equipment if required. Staff interviewed reported that they have adequate space to provide cares to residents. Residents are encouraged to personalise their rooms.</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>There are two large lounges and three smaller seating areas throughout the facility. There is a main dining room. A second dining room is available for residents with higher needs but was not in use as a dining room during the audit. Activities occur throughout the facility and in the lounge areas. Activities occur in any of the lounges and they are all large enough so there is no impact on other residents not involved in activities. Seating and space is arranged to allow both individual and group activities to occur.</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 undertaken on site. There is a well organised laundry and it is divided into a “dirty” and “clean” area and staff manage the workload adequately. There are appropriate systems for managing infectious laundry, which laundry staff could describe. There is a comprehensive laundry manual; cleaning and laundry services are monitored through the internal auditing system and the resident satisfaction surveys. The cleaners’ trolleys were attended at all times or locked away in the cleaning rooms as sighted on the day of the audit. There is a sluice room for the disposal of soiled water or waste.</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>Policies are in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There was a first aid trained staff member on every shift. Fire drills occur six monthly within an approved fire evacuation plan. Smoke alarms, sprinkler system and exit signs were in place. The service has alternative gas facilities for cooking in the event of a power failure with a backup system for emergency lighting. There is a civil defence kit in the facility and stored water. There is evidence of new initiatives since the earthquakes in 2011; all residents have their own bottled water supply; all beds are kept in the lowest position and flat when not in use and all beds and wheelchairs have brakes on at all times; extra supplies are safely stored; the nurse manager confirmed access to a generator and community support available in the event of a disaster. Call bells are evident in residents’ rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility has sufficient natural light. There is overhead heating in the corridors and main areas. Rooms have an overhead heater with an individual control panel in each room.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	FA	<p>The nurse manager is the infection control coordinator and has a job description that outlines the responsibility of the role. The new managers</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>reported they intend to train and appoint a registered nurse to this role. The infection control coordinator provides monthly reports to the quality meeting. The infection control programme has been reviewed annually.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents and staff are offered the annual influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has attended a Bug Control study day in 2016, is on the Canterbury IPC community committee, and was on the development committee for the Canterbury Health Information Pathways. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator has access to the infection control nurse specialist at the DHB, laboratory technician, GPs and public health.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The content of policies reflected current good practice.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection prevention and control education is included in the staff orientation and is included in the infection control calendar. Resident education occurs as part of daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance of infections that require antibiotics to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. A monthly surveillance report includes number of infections</p>

		<p>by type, trends identified and any corrective actions required. Infection control data and relevant information is displayed for staff. Definitions of infections are in place, appropriate to the complexity of service provided. Infection control data is discussed at quality meetings. Internal audits for infection control are included in the annual audit schedule.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. No residents were using restraints and three residents were using enablers (bed rails). Interview with one resident and review of enabler documentation for two residents demonstrated that enabler use is voluntary.</p> <p>Staff receive mandatory training around restraint minimisation. All care staff interviewed could describe the difference between an enabler and a restraint and a variety of interventions they use to minimise restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	The existing manager is a registered nurse and undertakes the clinical manager responsibilities. She is supported by a clinical coordinator, in a senior nurse position. The clinical coordinator has previously had clinical management responsibilities. The nurse manager, clinical coordinator and prospective owner report that informal discussions have been held about this person being offered the clinical management role but formal negotiations have not commenced.	The prospective owner does not have a clinical manager appointed.	<p>Ensure a clinical manager is appointed and HealthCERT and the DHB notified prior to the change of management.</p> <p>30 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and</p>	PA Low	Medication is securely stored and expired medication securely/correctly disposed of. Medications are checked on delivery against the medication chart. Medication	i) Three monthly medication reviews had not been regularly completed every three months for four residents' medication charts.	i) Ensure all medication charts are reviewed at least three monthly

<p>communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>		<p>errors are reported and annual medication audits completed. Medication trolley, fridge and cupboard stock contents were all within expiry dates. Nine of thirteen medication charts sampled had been regularly reviewed three monthly by the GP. All reviews were current at the time of the audit but prior reviews were longer than three months apart for these files. All medications and treatments were prescribed except one resident using oxygen. Every resident has a long list of standing order medications signed individually by the GP in the medication file. The standing orders did not meet requirements.</p>	<p>ii) Oxygen was not documented on the medication chart for one resident requiring oxygen.</p> <p>iii) Standing orders did not meet the requirements of the Standing Order Guidelines.</p>	<p>ii) Ensure oxygen is charted correctly</p> <p>iii) Ensure standing orders meet the requirements of the Standing Order Guidelines.</p> <p>60 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>Homestead Ilam experienced significant damage during the February 2011 earthquakes in Canterbury. Several structural engineering reports document that the building is safe to occupy until repairs occur, but the damage has resulted in the requirement for significant repairs to return the building to a suitable facility for aged care residents. Protracted insurance negotiations were settled in mid-2016 and the prospective owner reported that they are aware of the need for significant improvements to the building.</p>	<p>The facility has not yet had earthquake repairs completed following insurance company difficulties, meaning there are temporary, not long-term repairs in several areas (dining area walls and ceiling, pole supporting beam in dining room, uneven floor surfaces, patched holes in floors and ceilings and carpet that has stretched in places creating a trip hazard).</p>	<p>Ensure earthquake repairs are carried out and damage to the building repaired.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.