

# Karaka Court Limited - Woodlands of Feilding

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Karaka Court Limited
<b>Premises audited:</b>	Woodlands Of Feilding
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 26 June 2017    End date: 27 June 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	40

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Woodlands of Feilding provides rest home and hospital level care for up to 80 residents. On the days of audit there were 40 residents.

The service built a new facility which opened on the 3rd May 2017. The facility was built within the grounds of the original Woodlands of Feilding facility and residents transferred across to the new facility.

The service is managed by a manager who is supported by a clinical nurse leader and a quality systems manager. The company director also plays a role in management.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner. The residents and relatives interviewed spoke positively about the care and support provided.

This audit has identified improvements required around staff training, food storage and the completion of a fire evacuation drill.

## 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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Woodlands of Feilding practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends can visit at any time and ongoing involvement with community activity is supported. Residents and relatives are informed about the complaints process and complaints are well managed.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation has an annual business and quality plan in place with annual quality objectives. Quality information is reported to monthly quality/risk staff meetings. The service is actively involved in ongoing quality projects to improve outcomes and service delivery for the residents. The service has policies/procedures to provide rest home and hospital level of care. There is an orientation and training programme in place. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an information package for residents/relatives on admission to the service. Assessments (a plan is in place and being actioned to undertake interRAI assessments within required timeframes); care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly. The activity team (covering five days a week) provides an activities programme in the rest home and hospital. The programme meets the abilities and recreational needs of the groups of residents. The programme is varied and involves the relatives and community. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly. The menu is designed and reviewed by a dietitian who is available when needed. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food that was provided.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The building has a certificate of public use. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. Systems and supplies are in place for essential, emergency and security services. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. Some laundry services are managed on-site and some is laundered off-site.

## 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 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. Staff receive regular education and training on restraint minimisation. On days of audit there were four hospital level residents for which restraint was being used and one rest home resident was using an enabler.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator is responsible for coordinating and providing education and training for all staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. In practice, a very active ongoing focus on hand hygiene and outbreak management was maintained.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	47	0	2	1	0	0
<b>Criteria</b>	0	98	0	2	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Woodlands of Feilding practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Posters of the Code are displayed throughout the facility. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service. Interviews with eight care staff (four caregivers, two registered nurses (RN), one activities coordinator and one diversional therapist) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are policies in place for informed consent and the service is committed to meeting the requirements of the Code of Health and Disability Consumers Rights. There were signed general consents on all seven files sampled. The two registered nurses interviewed confirmed that family involvement occurs with the consent of the resident. Residents interviewed confirm good information was provided to them to make informed choices. Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives. Written directives are recorded for resuscitation status for six of seven files sampled (two from the hospital four from the rest home). The seventh file was for a hospital respite resident admitted during audit.</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	Residents and families are provided with information about the Nationwide Health and Disability Advocacy Service. Advocacy pamphlets are displayed in the entrance to the facility. Caregivers interviewed were aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	The service maintains key linkages with other community and external groups including churches and schools. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Discussion with staff, residents and relatives, determined that residents are supported and encouraged to remain involved in the community.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	There is a complaints policy to guide practice. The manager leads the investigation and management of complaints (verbal and written). There is a complaints and compliments register. Complaints are discussed at the monthly staff meeting. There have been no complaints made in the year 2016 and one complaint received in 2017, year-to-date. The complaint reviewed was investigated with the follow-up and outcome documented. Discussion with residents and relatives confirm they are aware of how to make a complaint. A complaints procedure is provided to residents within the information pack on admission. There have been a number of compliments that have been received across the 2016 and 2017 period.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. The manager or clinical nurse leader discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the six-monthly resident/family meetings. Seven residents (two hospital and five rest home) and two relatives (rest home) interviewed reported that the residents' rights are being upheld by the service and that they received sufficient information to be able to make informed choices on matters that affect them.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff received training in April 2017.</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 service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Māori consultation is available through local Māori services. Links are established with local Kaumātua and the district health board (DHB) Māori unit. Staff receive education on cultural awareness during their induction to the service (link 1.2.7.5). Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. At the time of the audit there were no residents in the service who identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the residents' 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>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregiver's 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>The owner/director and manager are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents interviewed state they are very happy with the level of care provided and with the move to the new facility. The service has implemented policies and procedures that are developed and reviewed by the quality systems manager. The policies and procedures meet legislative requirements. Caregivers interviewed state there are caregivers' guidelines in place to</p>

		guide the delivery of care to residents.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms reviewed identified family were notified following a resident incident. Interview with staff confirm that family are kept informed. Two families interviewed confirmed they were notified of any changes in their family member's health status. Interpreter services are available as needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The service has built a new facility within the grounds of the original Woodlands of Feilding facility. The service provides care for up to 80 residents across two service levels (rest home and hospital) and two 40 bed units (Karaka and Totara). The service opened the Karaka 40 bed unit on 3 May 2017 (two wings of 20 beds each). On the day of audit there were 40 residents in total that transferred across, 27 rest home residents and 13 hospital residents, including one resident on a long-term support chronic health condition (LTSCHC) contract and one resident on respite. One wing in the Totara 40 bed unit is due to open on in early July 2017. All 80 beds are dual-purpose beds.</p> <p>The manager reports to the owner/director who lives locally and has a regular presence at the facility. Karaka Court Limited has a 2016 – 2017 business contingency plan that includes goals and objectives and has been updated to include the new facility. There is a quality programme being implemented that includes monthly discussion about clinical indicators (e.g., incident trends, infection rates), at the monthly staff meeting.</p> <p>The service is managed by a non-clinical FTE manager who has been in role since 2001 and has been in the aged care industry for 30 years. The manager is supported by a FTE clinical nurse leader (RN) and has been in post since 2009. There is a team of six RNs who have experience within the aged residential care environment. A quality systems manager (RN) has been employed (2 days a week) since March 2017.</p> <p>The manager and clinical nurse leader have maintained at least eight hours annually of professional development activities related to managing a hospital through attending regular DHB provider meetings.</p>
Standard 1.2.2: Service Management The organisation ensures the day-	FA	During a temporary absence, the clinical nurse leader will cover the manager's role. A senior RN will oversee the clinical nurse leader when she is on leave. Both the manager and clinical nurse leader are on-call afterhours dependant on the issue (i.e., clinical vs non-clinical). The owner/director is also

<p>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>		<p>available afterhours.</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>	<p>FA</p>	<p>Woodlands of Feilding is implementing a quality and risk management system. There are policies and procedures to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis by the quality systems manager. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures align with current practice. The clinical nurse leader collates incident and infection data. Data is recorded accurately and is reported at staff meetings (sighted).</p> <p>Quality matters are taken and discussed at the monthly quality/risk staff meetings. There are monthly resident meetings. Meeting minutes demonstrate key components of the quality management system discussed including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings (monthly).</p> <p>Woodlands of Feilding is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are seen to be resolved at the time. Corrective action plans are developed, implemented and signed off as completed when service shortfalls are identified. Internal audit results are communicated to staff at the full staff and RN meetings. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. A resident and relative satisfaction survey is completed annually. The 2016 relative satisfaction survey showed an overall satisfaction at 100% of either being very satisfied or satisfied with the service.</p> <p>There is a H&amp;S and risk management programme in place including policies to guide practice. A hazard register is in place. Health &amp; Safety policy has been reviewed and reflects current H&amp;S legislation. The Quality system Manager is a qualified accident investigator and has attended a H&amp;S update. The manager is the H&amp;S Coordinator.</p> <p>H&amp;S ii included at the quality improvement meetings for all staff. Staff have attended induction to new facility which included H&amp;S.</p> <p>Falls prevention strategies are in place that includes analysis of falls incidents and the identification of</p>

		interventions on a case by case basis to minimise future falls
<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>	FA	<p>Incident and accident data has been collected and analysed. A sample of ten resident related incident reports for May and June 2017 were reviewed. All incident reports and corresponding resident files reviewed, evidenced that appropriate clinical care has been provided following an incident and all have been signed off. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise, and debriefing. Monthly and annual review of incidents is completed. Discussions with the owner/director and manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (one manager, one clinical nurse leader, one cook, one RN and two caregivers) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed. A register of RN practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files reviewed). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. All staff have completed a site-specific induction to the new facility on opening.</p> <p>Not all required training has been provided over the last two years. A competency programme is in place with different requirements according to work type (e.g., caregiver, RN and kitchen). Core competencies are completed and a record of completion is maintained, with signed competency questionnaires sighted in files reviewed. There is a staff member with a current first aid certificate on every shift. There are currently six RNs working at Woodlands of Feilding. Three of the six RNs are interRAI trained, including the clinical nurse leader.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The service opened one unit on 3 May 2017 (two wings of 20 beds each). All rooms are dual-purpose. The roster allows for flexibility depending on the needs of the residents (i.e., hospital or rest home level). The roster (40 residents) includes the clinical nurse leader working five mornings a</p>

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		week. The manager and clinical nurse leader are both on call. There is at least one RN and one first aid qualified person on each shift. Staffing is as follows: five caregivers in the morning (various times), five during the afternoon (various times) and one on night shift (11.00pm-7.30am). The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times. There is a further draft roster for the opening of the second unit (proposed for up to 60-80 residents). Another RN will be rostered 24/7 in that unit. The roster also allows for a 'float/lounge carer' for each lounge as deemed necessary.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the service's contracts. Six of seven admission agreements viewed were signed, the seventh was a respite resident.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that describes 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. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management including the receipt and storage of medications was in accordance with the Medicine Care Guide for Residential Aged Care 2011. Medication reconciliation is completed by an RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior care staff who administer medications have been assessed for competency on an

<p>requirements and safe practice guidelines.</p>		<p>annual basis. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided and monthly audits undertaken along with a six-monthly audit by the pharmacy.</p> <p>Standing orders are not used. One self-medicating resident had been assessed by the GP and RN as competent to self-administer and this had been reviewed three-monthly. Fourteen medication charts were reviewed (six hospital level and eight rest home level). An electronic system for medication charting and administering is used. Medications are reviewed at least three-monthly by the GP and all medication charts reviewed have as needed medications prescribed with an individualised indication for use.</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>PA Low</p>	<p>The service employs two cooks who are supported by kitchen staff. All staff have been trained in food safety and chemical safety. There is a four weekly, two season menu that had been designed by the dietitian. The menu was currently being reviewed with the last review being June 2015. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as vegetarian and pureed/soft and gluten free meals are provided. Food is plated in the kitchen and delivered in scan boxes. Fridge and freezer temperatures are checked daily. Not all food was labelled, dated and stored correctly. A cleaning schedule is maintained. Feedback on the service is received from one-to-one feedback, resident meetings, surveys and audits.</p> <p>Residents and relatives were very satisfied with the food including the presentation of the food.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason/s for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry was referred back to the needs assessment service or referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	<p>FA</p>	<p>The facility has embedded the interRAI assessments within its clinical practice. InterRAI initial assessments and assessment summaries were evident in the files reviewed. Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. Additional</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>assessments such as management of behaviour, and wound care were completed according to need. In the resident files reviewed the outcomes of all assessments, needs and supports required were reflected in the care plans. Four weeks prior to audit an additional RN who is interRAI trained was employed and there is a plan in place to address some of the interRAI assessments due in the month of June 2017 and to maintain interRAI assessments within timeframes.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed demonstrated service integration and input from allied health. All resident care plans sampled were resident centred and support needs and interventions were documented in detail. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect changes in health status and were reviewed on a regular basis.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Wound assessments, treatment and evaluations were in place for all current wounds. In the hospital, there was one resident with a lesion and another with a leg ulcer. In rest home care, there was a resident with a skin tear. Adequate dressing supplies were sighted in the treatment room.</p> <p>There were two hospital residents with a grade 2 pressure injury (one was on respite). The long-term resident's injury was sacral and the respite resident was admitted with a PI on the thigh. Pressure injury prevention strategies were included in the long-term care plan of the resident with pressure injuries. The GP had been notified of the wound. RNs had received education on wound management. Pressure injury prevention strategies were included in the long-term care plan of the residents at risk of pressure injuries. Staff receive regular education on wound management. Continence products are available and resident files include urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. Monitoring forms are in place to continually assess a resident's progress where there is a change in health status.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements</p>	<p>FA</p>	<p>The activity team (one diversional therapist and one activities officer covering five days of the week) implement an activity programme for the rest home/hospital. The programme has set activities with the flexibility to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group and are gender appropriate. The programme is also displayed throughout the facility</p>

<p>are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>and each morning it is announced over the sound system.</p> <p>Activities were observed to be delivered along with input from volunteers. Contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There is a van to facilitate outings to events for residents (as appropriate). Visits from entertainers occur monthly and there are a wide range of visiting speakers. On-site church services are held in the facility chapel room. The programme also includes exercise sessions and a range of intellectual, craft and fun activities.</p> <p>Attendance logs and a record of individual resident's activities is kept. Activity staff complete weekly recreational progress and evaluation notes in the residents' files. The activity plan in the files reviewed had been evaluated at least six-monthly (more frequently when resident's condition indicated) with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan and a number of relatives actively participate. Resident/relative meetings were held monthly.</p> <p>Residents and relatives expressed satisfaction with activities offered with particular comment on the interesting speakers that came to the facility.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses six-monthly or when changes to care occurred. Written evaluations described the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident. Referral documentation is maintained on resident files. There was evidence of referrals to the DHB and input from physiotherapist (by referral), dietitian, wound clinical nurse specialist (if a wound does not heal within three weeks a referral is made) and the incontinence specialist. The service facilitates access to other medical and non-medical services.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets were available.</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>	FA	<p>The building is new and has a certificate for public use (CPU), with the expiry date 4 August 2017 when a building warrant of fitness will be undertaken.</p> <p>One of the Karaka Court Trust members provides maintenance services to Karaka Court Ltd. There is a proactive maintenance schedule for 2017– 2018. Daily maintenance requests are addressed and electrical testing, calibration and functional checks of medical equipment has been completed by an external contractor. Hot water temperatures in resident areas are monitored. Contractors are available 24 hours for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is a range of seating and activity areas (including a chapel, a library and a dedicated room for family functions) for residents and families to use. Fixtures, fittings, furnishing are all new and along with the level of lighting is suitable for residents. Residents were observed to access the outdoor gardens safely. Seating and shade is provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>All bedrooms are single occupancy with ensuite. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when personal cares are undertaken.</p>
<p>Standard 1.4.4: Personal</p>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and</p>

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</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>	<p>FA</p>	<p>There are large lounge and dining areas with seating placed to allow for individual or group activities. There are a number of areas which residents/family can choose to use. The communal areas are easily accessible.</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>	<p>FA</p>	<p>There are policies/procedures and audits of the cleaning and laundry service. The laundry had an entry and exit door with defined clean/dirty areas. There is a secure area for the storage of cleaning and laundry chemicals for the laundry. There are dedicated cleaning and laundry persons on duty each day. All personal clothing and towels are laundered on-site and sheets and pillowcases are laundered off-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner.</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>	<p>PA Moderate</p>	<p>Appropriate training, information and equipment for responding to emergencies is provided. There is an evacuation plan approved by the NZ Fire Service, which is dated 13 March 2017. A fire evacuation drill has not been completed at the new facility. There is staff across 24/7 with a current first aid certificate. There is an emergency management plan in place (dated November 2016) that covers the new facility and covers health, civil defence and other emergencies. The civil defence kits are readily accessible. The new facility is well prepared for emergencies and has emergency lighting, gas BBQ for alternative cooking and access to a generator.</p> <p>One large water tank has been installed next to the building and a further water tank will be installed when the second unit is fully opened. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery backup. At least three days stock of other products such as incontinence products and PPE are kept. There are supplies necessary to manage a pandemic. The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. There are documented</p>

		security procedures in place.
<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>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight and individual heating controls. The living areas including the large foyer containing a number of sitting areas was well lit.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control coordinator (clinical nurse leader). The infection control programme is linked into the quality management system and reviewed annually (March 2017) by the clinical nurse leader in consultation with the quality systems manager. Infection control is an agenda item on both the quality and risk meetings (22 June 2017) and the registered nurse meetings.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff.</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 been in the role for nine years and has attended external education annually including an online course in March 2016 and attended IPC and QM training in December 2016. The infection control coordinator provides monthly reports to management and staff meetings. The infection control coordinator has access to an infection control unit at the local DHB and the public health office.</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</p>	FA	<p>There are infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies (last reviewed by the quality systems manager in June 2017) link to other documentation and cross reference where appropriate.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the annual training programme. Staff are required to complete infection control questionnaires and random monthly hand hygiene audits. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections. 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 the monthly meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule. The systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since December 2011.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified and other strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. There were four hospital residents with restraints and one rest home resident using an enabler during the audit. There is documented evidence of consultation with the resident and family/whānau regarding the use of enablers and restraint. The resident files were reviewed and all were reviewed six-monthly by the GP. The enabler in use had been verbally requested by the resident (witnessed and documented). There is a restraint coordinator (clinical nurse leader) and evidence showed there had been a restraint audit undertaken in June 2017 and subsequent discussion at the RN meeting. Staff receive training around restraint minimisation on

		orientation and as part of the annual education programme.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is the clinical nurse leader with a job description that defines the role and responsibility of the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Staff are educated on the safe use of restraint and the risks of restraint and monitoring required are documented
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RN in partnership with the restraint coordinator, approval group, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Three hospital level residents' files with restraint use (bedsides and a lap belt for two and bedsides for one) sampled showed GP assessments that meet the requirements of criterion 2.2.2.1 had been undertaken.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Risks associated with enabler and restraint use were documented in care plans and monitoring records demonstrated regular monitoring of restraint use. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Evaluations occur six-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of the care plan review. Families are included in the review of restraint use. Files reviewed for residents with restraint use evidenced evaluations were up-to-date.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraints are discussed and reviewed at the six-monthly restraint meetings. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme, staff education and training and review.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	There is an education and training calendar schedule for 2017 documented. Not all mandatory training has been completed within the required two-year period.	Not all mandatory training has been completed within the required two-year period. The mandatory training not completed during this period was nutrition/hydration, wound care, cultural awareness, and management of challenging behaviour.	<p>Ensure that all mandatory training is provided within the required two-year period.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	The service employs two cooks who are supported by kitchen staff. There was no evidence of a process that covers stock control of food consistently.	Spices in the dry store had passed use by dates. Prepared food placed in fridge was not dated. One container of food in the dry store was not clearly labelled and there was no evidence of consistent dating, rotation and correct storage of stock.	Ensure all aspects of food procurement and storage complies with current legislation and guidelines.

				60 days
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA</p> <p>Moderate</p>	<p>There is an evacuation plan approved by the NZ Fire Service, dated 13 March 2017. A fire evacuation drill has not been completed at the new facility.</p>	<p>A fire evacuation drill has not been held for the new facility since it opened.</p>	<p>Ensure a fire drill occurs for staff in the new facility.</p> <p>30 days</p>

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

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

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

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

No data to display
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End of the report.