

Lara Lodge 2017 Limited - Lara Lodge

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 HealthShare 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:	Lara Lodge 2017 Limited	
Premises audited:	Lara Lodge	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 1 February 2018	End date: 1 February 2018
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	14	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lara Lodge 2017 Limited trading as Lara Lodge can provide care for up to 27 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The service can provide care for residents requiring rest home level of care. The service can also provide residential care for those needing Long term Support - Chronic Health Conditions, plus palliative care.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager and communications manager (both owners are responsible for the overall operational management of the service and they are supported by the clinical nurse manager who provides clinical oversight. Service delivery is monitored.

Improvements are required to integration of resident records; review of use of restraint and alignment of completion of interRAI assessments and documentation of care plans.

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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents' and their families on entry to the service and when requested. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

Consent is documented and verbally ascertained on a daily basis and residents and family are given relevant information.

The communications manager is responsible for management of complaints and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed and there is a document control process in place.

There are human resource policies implemented around selection of staff, orientation and staff training and development. Staff, residents and family confirm that staffing levels are adequate, and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

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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The registered nurse is responsible for the development of care plans with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. Residents and family/whanau expressed satisfaction with the activities programme.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner every three months or as when necessary according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. Residents and family interviewed confirm that adequate fluids and food are provided. Snacks are available between meals or whenever needed.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is in place and a New Zealand Fire Service evacuation scheme is approved. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

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.		Some standards applicable to this service partially attained and of low risk.
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There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using enablers at the time of the audit and one resident using a bedrail identified as a restraint. Staff interviewed demonstrated understanding of restraint and enabler use and receive ongoing education around restraint and management of challenging behaviour.

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 management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

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	47	1	2	0	0	0
Criteria	0	98	1	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents state that they receive services that meet their cultural needs, receive information relative to their needs and that staff respect their wishes. Staff can explain rights for residents in a way that promotes choice. The posters identifying residents' rights are displayed in the facility.</p> <p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual education programme. All staff have had training in the last year. Interviews with staff confirm their understanding of the Code.</p> <p>Examples are provided on ways the Code is implemented in everyday practice, including maintaining residents' privacy; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to gathering consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>the planning of that care. All resident files identified that informed consent is collected and recorded. Interviews with staff confirmed their understanding of the informed consent process.</p> <p>The service information pack includes information regarding informed consent. The clinical nurse manager, registered nurse or the communications manager discusses informed consent processes with residents and their families during the admission process.</p> <p>The policy and procedure includes guidelines for consent for resuscitation/advance directives. Advanced directives are signed by a resident deemed competent to make a decision.</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>Written information on the role of advocacy services is provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service.</p> <p>Staff training on the role of advocacy services is included in training on the Code and this was last provided for staff in 2017.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about 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 has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirm they could visit at any time and were always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friend's networks. Resident files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments with staff able to take residents into the community.</p>
<p>Standard 1.1.13: Complaints Management</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Code and</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place noting that there have not been any complaints since the last audit. There is a multidisciplinary meeting held annually with each file reviewed including input from family member/s. The satisfaction expressed through interviews and through documentation on the multidisciplinary review indicates that family and residents are very satisfied with the service provided.</p> <p>There have been no complaints with external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The clinical nurse manager, communications manager or other registered nurse discusses the Code, including the complaints process with residents and their family on admission.</p> <p>The information pack includes information around rights and this can be produced in a bigger font, if required. Information is given to next of kin or an enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members can describe their rights and advocacy services particularly in relation to the complaints process.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.</p> <p>The service ensures that each resident has the right to privacy and dignity. The resident's own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings.</p> <p>Caregivers report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. Practices consistent with this were observed on the days of the audit. Residents and families confirm that residents' privacy is respected.</p>

		<p>Staff state that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training annually on abuse and neglect and can describe signs. There were no incidents of abuse nor neglect reported in incident forms reviewed nor any documented on the complaints register. Residents, staff and family interviewed confirm that there is no evidence of abuse or neglect.</p> <p>Staff interviewed are aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.</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>	FA	<p>The organisation has a policy that outlines the processes for working with people from other cultures. There is a Māori health policy that outlines how to work with Māori with reference to the Treaty of Waitangi.</p> <p>Staff report that specific cultural needs for Māori are identified in the specialised Māori assessment and in the residents' care plans. The manager states that the service can access a kaumatua if required. This may be to support the service around tikanga protocols or general advice. The rights of the resident and family to practise their own beliefs are acknowledged in the policy.</p> <p>Staff who identify as Māori can provide support for any Māori residents in the service.</p> <p>Staff are aware of the importance of family/whanau in the delivery of care for the Māori residents. Staff have completed training within the last year around culture including the Treaty of Waitangi and appropriateness of services for 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>	FA	<p>The r clinical nurse manager or registered nurse identifies each resident's personal needs at the time of admission through the assessment process. This is achieved with the resident, family and/or their representative as described by family and residents interviewed. Information gathered during assessment includes the resident's cultural values and beliefs.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. There are a no residents for whom English is a second language. Resident records reviewed during the audit reflected assessment of and planning to meet cultural needs when identified.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff describe implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy.</p> <p>Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination or exploitation.</p> <p>Job descriptions include responsibilities of the position with a job description sighted in staff files sampled. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service implements policies to guide practice. These policies align with the health and disability services standards and are reviewed as legislation and evidence changes. There is a training programme for all staff with a high level of attendance from staff. Residents and families expressed a high level of satisfaction with the care delivered.</p> <p>Consultation for staff is available through the clinical nurse manager, the registered nurse, the general practitioner and specialists at the District Health Board if required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is provided. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family confirm that there is a lot of communication from the communications manager, facility manager, clinical nurse manager and registered nurse and they are encouraged to visit at any time.</p> <p>Family contact is recorded in residents' files. Family confirm that they are invited to the</p>

		<p>care planning meetings for their family member and can attend the resident meetings. Residents who attend the resident meetings confirmed that they are useful forums to raise issues.</p> <p>Residents sign an admission agreement on entry to the service. Those reviewed are signed on the day of admission. The admission agreement provides clear information around what is paid for by the service and by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The two owners/directors are identified as the facility and communications managers. They are on site daily with weekly manager meetings (including the clinical nurse manager). The strategic direction for the organisation is documented. The purpose, values, scope, direction, and goals of the organisation are identified and have been reviewed within the past year</p> <p>There is an established organisational structure, with the owners/managers and clinical nurse manager providing operational and clinical oversight respectively.</p> <p>The facility and communications managers have over 10 years' experience in providing support for people with disabilities.</p> <p>The clinical nurse manager provides clinical oversight (a full-time role). The clinical operations manager was appointed to the role in September 2016 and they are a registered nurse. The clinical nurse been in the role for over one year and has extensive experience in secondary health services and in aged care. The clinical nurse manager maintains their eight hours professional development per annum and the communications manager continues to have over eight hours training in management. Both can describe their roles related to their areas of expertise.</p> <p>On the day of audit, there were 14 residents in the facility requiring rest home level of care. The service can provide care for residents identified under the Long term Support - Chronic Health Conditions or for palliative care however there were no residents requiring care under these contracts on the day of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision</p>	FA	<p>In the absence of the owners/facility and communications managers, the clinical nurse manager would provide operational management of the service. The clinical nurse manager has completed management training in the past.</p> <p>A registered nurse has been appointed recently into the service and is being supported</p>

<p>of timely, appropriate, and safe services to consumers.</p>		<p>by the clinical nurse manager to gain experience in aged care. It is expected that they will provide support from a clinical perspective if the clinical nurse manager is on leave.</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>There is a quality plan in place and a risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to review two yearly and as changes in legislation occurs. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy.</p> <p>Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any clinical issues; feedback from residents and family and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues.</p> <p>The schedule of meetings includes a two-monthly staff meeting with emails circulated to staff as issues arise. The meeting includes all aspects of the quality and risk management programme. There is a monthly resident meeting facilitated by the owner/communications manager and family are also able to attend if they wish. The meetings are well attended. Staff report that they are kept informed of quality improvements.</p> <p>Resident and family satisfaction of the service is gathered through the resident meeting, the multidisciplinary meeting and through an open-door policy confirmed as being in place by family and residents interviewed.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise, and risks are eliminated, minimised or isolated. Health and safety is audited monthly. Review of incidents, risks, accidents and clinical issues are discussed through meetings as part of the health and safety programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>The clinical nurse manager and communications manager are aware of situations in which the service would need to report and notify statutory authorities including: police</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>attending the facility; unexpected deaths; sentinel events; infectious disease outbreaks and changes in management.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and can describe the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes in each relevant resident record. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The clinical nurse manager and registered nurse hold a current annual practising certificate along with other health practitioners such as the general practitioner, podiatrist and pharmacist involved with the service.</p> <p>Staff files include appointment documentation including signed contracts; job descriptions and reference checks. There is an appraisal process in place with staff files indicating that staff have an annual appraisal.</p> <p>All staff complete an orientation programme and caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Caregivers confirmed their role in supporting and buddying new staff. There is a low turnover of staff.</p> <p>The organisation has an annual training schedule documented with all staff attending each training offered. The content of each session is retained along with documentation of attendance and evaluation of each session. Education and training hours are at least eight hours a year for each staff member. The clinical nurse manager and registered nurse have both has completed interRAI training with certificates sighted.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy with sufficient staff to cover shifts if others are on leave. Staff are rostered on for an eight-hour shift across a 24-hour period with rosters reviewed indicating that staff are replaced when on leave.</p>

		<p>There are 20 staff including the clinical nurse manager (40 hours a week); a registered nurse (32 hours a week); care staff and household staff. The clinical nurse manager and registered nurse alternate on call with the communications manager and the clinical nurse manager also available at all times if required. Cooks prepare all meals. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant staff member with their designation documented.</p> <p>Resident files are protected from unauthorised access at all times.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Individual residents' files have been divided into separate folders and forms onto clip boards. Files are therefore not integrated, and an improvement is required.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. There is an information pack provided to a potential resident and family that contains all the information about entry to the service. Assessments are documented. Screening processes are clearly communicated to the family of choice where appropriate, local communities and referral agencies. Each resident file reviewed included a needs assessment that outlined the level of care required.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the District Health Board is utilised when residents are required to be transferred to the public hospital or another service.</p>

<p>coordinated transition, exit, discharge, or transfer from services.</p>		<p>Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this. Any risks are documented and included in any transfer, exit or discharge information.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>All medication entries sampled confirm that they are reviewed every three months and as required by the general practitioner.</p> <p>Allergies are clearly documented, and photographs uploaded for easy identification. Medication reconciliation is conducted by the clinical nurse manager or registered nurse when a resident is transferred back to the service.</p> <p>The caregiver was observed administering medication as per policy and procedure. The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner and medication entries sampled complied with legislation, protocols and guidelines.</p> <p>Medications are stored in a safe and secure way in the office and locked cupboard.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted indicating that competencies are current.</p> <p>The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted, and all medications are stored appropriately in a safe within a locked cupboard. Balances checked on audit day matched those recorded in the controlled drug register.</p> <p>There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required. There is a social leave medication form that is used if the resident stays overnight at their family residence and balances and medication is checked prior to leaving and on return of the resident.</p> <p>Medicines that are opened that expire within a certain period are dated when opened.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a</p>	<p>FA</p>	<p>Meal services are prepared on site and served in the dining area. The menu has been reviewed by a dietitian two years ago and has recently been also reviewed by a nutritionist. A chef has been employed to manage food services and they have documented a food plan as per changes in recent legislation.</p>

<p>component of service delivery.</p>		<p>The kitchen staff have current food handling certificates. Diets are modified as required. The chef confirmed awareness on dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. The resident's weight is monitored regularly, and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family interviewed indicated that they were very satisfied with the food service.</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 clinical nurse manager reports that all consumers who could be declined entry would be verbally informed of this noting that there are no consumers who have been declined entry as all have been assessed as requiring rest home level of care by the needs assessment service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews, residents and relatives expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short-term care plans for acute needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled included six monthly input from the multidisciplinary team including the resident and family. The residents and relatives interviewed confirm care delivery and support is consistent with their expectations and plan of care.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The documented interventions in short term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they needed.</p> <p>The general practitioner interviewed states that staff escalate any issues (for example changes in a resident's needs) in a timely manner and staff follow up prescribed interventions.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The communications manager coordinates the activities programme with modification of the programme as per individual needs; based on the resident's response and interests and also according to the capability and cognitive abilities of the residents. Activities include music, bingo, van outings, book and newspaper readings, church services respectively.</p> <p>Staff are actively involved in supporting residents to achieve their goals related to socialisation and activity.</p> <p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</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>The long-term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The general practitioner confirms that processes are in place to ensure that all referrals are followed up accordingly in a timely manner. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or the general practitioner.</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>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility with an expiry date of July 2018. There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule is implemented. Any maintenance issues identified by staff are logged and attended to by the owner/facility manager.</p> <p>Indoor and outdoor space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas for residents to sit.</p> <p>Equipment relevant to care needs is available and staff confirmed that there is always a sufficient amount of equipment. A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use and these include paths, seating and shade.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities. Communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant or a lock system.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers with all bedrooms having a hand basin.</p> <p>The auditor observed residents being supported to access communal toilets and showers in ways that are respectful and dignified with the ability to have privacy.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.</p> <p>Rooms are personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</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>The service has a lounge and dining area with these spaces able to be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.</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>Laundry is completed on site with covered laundry trolleys and bags in use for transport. The laundry area has been reorganised to ensure that there are clean and dirty spaces. Dirty laundry was observed to be kept separate from clean laundry on the days of the audit. Residents and family members state that the laundry is well managed, and they seldom have missing clothes.</p> <p>The cleaner has a locked cupboard to put chemicals in and the cleaner is aware that the</p>

		<p>trolley must be with them at all times. This was observed on the days of audit.</p> <p>Chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning and laundry processes are monitored through the internal audit process with no issues identified in audits.</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>The New Zealand Fire Service has approved an evacuation plan. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six monthly with all staff having completed training. The orientation programme includes emergency and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member on duty with a first aid certificate.</p> <p>All required fire equipment is checked within required timeframes by an external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and a gas BBQ. Emergency lighting is in place.</p> <p>The doors are locked in the evenings. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security.</p> <p>The call bell system is operational with bells in each room. Those tested on the days of audit were working and staff responded to call bells in a prompt manner. Residents interviewed confirm that staff attend promptly when a bell is activated.</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>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>The service is designated as a smoke free service however there is an external area available for residents if they smoke.</p> <p>Family and residents confirm that rooms are maintained at an appropriate temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. Either the clinical nurse manager or the registered nurse can access a general practitioner or specialist from the District Health Board when required. A documented job description for the infection control coordinator including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrate an understanding of the infection prevention and control programme.</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>	<p>FA</p>	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</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>	<p>FA</p>	<p>Staff demonstrate knowledge on the requirements of standard precautions and are able to locate policies and procedures. The organisation has documented policies and procedures in place that reflect current best practice for example, hand hygiene as per the World Health Organisation guidelines.</p> <p>The caregivers and cleaner were observed to manage waste correctly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</p>	<p>FA</p>	<p>Staff education on infection prevention and control conducted by ICC and other specialist consultants. A record of attendance is maintained and was sighted. The</p>

<p>infection control to all service providers, support staff, and consumers.</p>		<p>training education information pack is detailed and follows the policy and procedures documented. External contact resources included: general practitioner; laboratories and local district health board staff. Staff interviewed confirm an understanding of how to implement infection prevention and control activities into their everyday practice.</p> <p>The ICC (registered nurse) has completed training around infection control in 2017 with the certificate of completion sighted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The registered nurse or clinical nurse manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided. Infection control processes are in place and documented.</p> <p>The infection control surveillance register includes monthly infection logs and antibiotic use. Infections are investigated, and appropriate plans of action are sighted in meeting minutes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy provides consistent definitions for restraints and enablers. One resident used a bedrail on the day of audit which was identified as a restraint and there were no resident's enablers. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler.</p>
<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>	<p>FA</p>	<p>The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator (clinical nurse manager or registered nurse) completes a restraint assessment, which is then discussed with the general practitioner and family prior to commencement of any restraints. The restraint committee (staff meeting) is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint is documented in the restraint plans of residents. Care staff are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of on-going education regarding restraint and challenging behaviour is documented. Staff members are made aware of the residents using restraints during monthly staff meetings and at handover as observed on the day of</p>

		audit. This was confirmed during staff interviews
<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	<p>Restraint assessments include restraint related risks. The service records underlying causes for behaviour that requires restraint with a focus on culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.</p> <p>A file reviewed for a resident who used restraint confirmed that a comprehensive assessment was completed</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Before resorting to the use of restraint, the restraint coordinator (registered nurse) tries other means to prevent the resident from incurring injury. Restraint consents are signed by the general practitioner, family and the restraint coordinator. Restraints are incorporated in the long-term care plans and reviewed three monthly. The restraint register is up to date.</p> <p>Files were reviewed where the resident was using restraint (bedrail). They had documentation of risks around restraint and safe ways for the restraint to be used</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	PA Low	<p>The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.</p> <p>There is a lack of in depth discussion documented as part of the review of the individual use of restraint for one resident and an improvement is required.</p>
<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>	FA	<p>The facility demonstrates the monitoring and quality review of their use of restraints. The audit schedule was sighted and included restraint minimisation reviews. There are corrective actions put in place when issues are identified. The content of the internal audits includes the effectiveness of restraints, staff compliance, safety and cultural</p>

		considerations.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	PA Low	Resident files have been re-organised with forms on a number of clipboards; a file for immediate information including assessments and care plans; a file for the doctor with medical records; medication files and other. The medical officer interviewed stated that they found it difficult at times to see a whole picture, but they also stated that staff were very efficient in having all information ready for them when they visited.	Resident files are not integrated.	<p>Ensure that each resident has an integrated record.</p> <p>180 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Negligible</p>	<p>A registered nurse has been trained in completion of interRAI assessments. There has been a delay in the sign off of the registered nurses training and therefore a delay in documentation of the care plan after an interRAI assessment has been completed. The clinical nurse manager states that they have been aware of the delay due to the Christmas period and that while the care plans have been completed, they have not been signed off by the interRAI training assessor and therefore there appears to be a delay in completion of the documentation.</p>	<p>Timeframes for review of the care plan do not always align with the completion of the interRAI assessment.</p>	<p>Ensure that review of the resident care plans occurs in a timely manner following completion of the interRAI assessment.</p> <p>180 days</p>
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p>	<p>PA Low</p>	<p>The clinical nurse manager and registered nurse interviewed can both describe the review process to be implemented for use of a restraint. The review of the use of the restraint (bed rail) for one resident is identified in the interRAI assessment and referenced in the long-term care plan however an in-depth evaluation, re-assessment and subsequent care plan is not well documented.</p>	<p>An in-depth evaluation, re-assessment and subsequent care plan is not well documented.</p>	<p>Ensure that there is sufficient documentation of the use of restraint for an individual resident.</p> <p>180 days</p>

(j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers.				
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.