

Komal Holdings Limited - Homestead Ilam Home and Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Komal Holdings Limited

Premises audited: Homestead Ilam Home and Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 31 January 2017 End date: 1 February 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 35

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Homestead Ilam provides care for up to 39 rest home and hospital level residents. On the days of audit there were 35 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The facility is being managed by the (non-clinical) owner who purchased the service April 2017. The owner also owns another facility. The owner is supported by an acting clinical manager who is an experienced aged care registered nurse. A quality coordinator, also a registered nurse is employed to support the management team.

Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit identified that improvements are required around orientation documentation, staff training, staff rostering, care plan interventions and environment.

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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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. Management team have an open-door policy. The personal privacy and values of residents are respected. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Families and friends are able to visit residents at times that meet their needs. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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 medium or high risk and/or unattained and of low risk.
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The service has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Incidents are documented and there is immediate follow-up from a registered nurse. There are human resources policies including recruitment,

selection, orientation and staff training and development. There is a documented organisational staffing policy that includes skill mixes.

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.

The registered nurses take primary responsibility for managing entry to the service. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on-site. The menu is developed under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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 low risk.

The building has a current warrant of fitness and emergency evacuation plan. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are ventilated and heated. The outdoor areas are safe and easily accessible. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

There are staff on duty with a current first aid certificate. There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a first aider on-site at all times.

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.

The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with a restraint and three residents using enablers (lap belts and bed rails).

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the service and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers. The type of surveillance undertaken is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	40	0	3	1	0	0
Criteria	0	89	0	3	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Information related to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and their families. Discussions with seven care staff (four caregivers, two registered nurses (RN) and the diversional therapist) confirmed their familiarity with the Code. Interviews with seven residents (four hospital and three rest home), there were no family available on the days of audit, confirmed the services being provided were in line with the code of rights, and code of rights and advocacy training is provided as a regular in-service education and in July 2017.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has policies and procedures relating to informed consent and advanced directives. All seven resident files reviewed included signed informed consent forms and advance directive instructions. Staff are aware of advance directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents identified that the service actively involves them in decision making (as able).
Standard 1.1.11: Advocacy And	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Management staff inform that they provide opportunities for the family/enduring power of

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		attorney (EPOA) to be involved in decisions. Contact numbers for advocacy services are included in the resident information pack and in advocacy pamphlets that were available at reception.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and staff interviewed confirmed open visiting. Residents inform that relatives and friends are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirm the staff help them access community groups.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. There have been five complaints made in 2017. Documentation, including follow-up letters and resolution, demonstrated that complaints are well managed, with every effort made to meet with complainants. Discussion with residents confirmed they were well informed regarding the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Policies are in place around advocacy and resident rights. An information pack is provided to relatives and residents that includes information about the Code. The information pack is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents identified they were well-informed about the code of rights. Two monthly resident meetings and an annual resident/family survey provided the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and was available at reception. Large print posters of the Code and advocacy information are displayed throughout the facility and advocacy pamphlets are available in the foyer.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner	FA	The service has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while care was being undertaken. Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and

that has regard for their dignity, privacy, and independence.		dignity. Residents interviewed confirmed that the staff were supportive and caring, and assisted them with their choices. Staff education and training on abuse and neglect had been provided in June 2017.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Discussions with staff confirmed their understanding of the different cultural needs of residents and their family/whānau. At the time of the audit there were no residents at the service who identified as Māori. Homestead Ilam has a Māori health plan and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). All residents have their cultural needs recorded in the service delivery plan. Linkages with Māori community groups are available and accessed as required.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents' interviewed confirmed that their values and beliefs are considered, and that staff take into account their cultural values. The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. The care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents' needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules and a service code of conduct. Staff job descriptions include responsibilities. Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the seven staff files sampled. The RN and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the two clinical nurse managers (one acting and one on maternity leave - who came in for the audit) the diversional therapist, two registered nurses and four caregivers confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme monitored contractual and standards compliance and the quality of service delivery in the facility. Policies and procedures have been reviewed two yearly. These were available in hard copy. A variety of staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided.

		<p>Evidence-based practice is evident, promoting and encouraging good practice. A physiotherapist is available for four hours per week.</p> <p>The service has embarked on significant environmental improvements including; an extensive kitchen refurbishment, improvements to the courtyard such as a fountain and plants, a refurbished laundry, and interior and exterior painting and resident room refurbishments. New weighing scales, a new hoist and wheelchair have also been purchased. Staff and residents all remarked very positively on the improvements to the service.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about services and procedures. Six incident/accident forms were reviewed for the month of December 2017, all forms had documented communication with families. There are documented two monthly resident/relative meetings with information regarding service discussed at meetings. Management have an open-door policy. Residents and family were advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services, residents and their family/whānau and an open disclosure policy. If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.
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>Homestead Ilam provides care for up to 39 rest home and hospital level residents. Thirty-seven of thirty-nine beds are dual-purpose (two beds are rest home only). On the days of audit there were 35 residents. Ten residents were receiving rest home level care (including one on a LTSCHC) and twenty-five were receiving hospital level care. All except the short-term respite resident were on the age-related care contract (ARCC).</p> <p>The facility is being managed by the (non-clinical) owner who purchased the service April 2017. The owner also owns another facility. She has attended at least eight hours of training related to elderly care management in the last year. The owner is supported by an acting clinical manager who is a registered nurse, and she has worked at the service for ten years. The clinical manager works 40 hours per week and provides on-call. A quality coordinator, also a registered nurse is employed. The clinical manager is on maternity leave but continues to support the acting clinical manger, she attended the audit for both days. The clinical manager has completed at least eight hours of professional development around the management of a hospital facility in 2017.</p> <p>There is a documented business and quality plan 2018. Organisational and quality objectives are defined with evidence of monthly reviews.</p>

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	<p>The acting clinical manager along with the quality coordinator provide cover during a temporary absence of the manager.</p>
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	<p>The service has maintained a quality and risk management system since change of owner. The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current, and staff are informed of updates and changes.</p> <p>The service conducts a series of meetings as part of the quality management system including: two monthly staff meetings, two monthly quality meetings (the opposite month to staff meetings) and monthly caregiver and monthly RN meetings. Minutes of meetings are available to staff in the staff room as well as a meeting summary document available to staff in a memo folder. Minutes of the meeting document discussion of; health and safety, activities, clinical, kitchen services, care services, infection control, internal audits and incidents</p> <p>Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The most recent survey is in progress. A food service questionnaire sent July 2017 resulted in menu changes as suggested by the respondents.</p> <p>There is an internal audit schedule in place and this was documented as followed. Action plans were documented where areas of non-compliance were identified and followed up.</p> <p>There are monthly accident/incident and infection reports provided. There is a hazard management, health and safety, and risk management programme in place and up-to-date hazard register was viewed.</p> <p>The health and safety officer was interviewed. This caregiver who was voted into the role had an in-depth understanding of health and safety and her role.</p> <p>Falls prevention strategies are in place including post falls reviews, individual interventions for frequent fallers to reduce the incidence of falls.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service documents and analyses all incidents/accidents. All incident forms are entered onto a computer monthly and a report generated. All incident forms are checked by the quality coordinator to ensure that any actions have been implemented. Six resident related incident/accident forms were reviewed. Individual incident reports have been completed for each incident/accident, with immediate action noted. The data is linked to the organisation's health and safety programme trends, and individual resident risks were documented as followed up. The incident/accident forms reviewed documented immediate follow-up by a RN. Care plan interventions and/or short-term care plans were in place where needed following a resident fall. Discussions with the acting nurse manager, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There had been one section 31 notification made since the last audit relating to a wandering resident.</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>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (two RNs, four caregivers and one diversional therapist). All files included appropriate employment documentation and up-to-date performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practices, not all orientations were up-to-date or in place. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>An annual education schedule for 2018 is being implemented; not all compulsory subjects have been provided in the last two years and attendance is often low at training sessions. Registered nurses (RNs) are provided with RN specific training (such as NikiT for example).</p> <p>A competency programme is in place with different requirements according to work type. Four of nine RNs are trained in interRAI.</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>	PA Moderate	<p>An organisational staffing policy aligns with contractual requirements and includes skill mixes. The owner manager works 40 hours per week. The acting clinical nurse manager works 40 hours a week and provides on call. The quality coordinator (RN) also works Monday to Friday and an occasional weekend shift.</p> <p>Staffing for the rest home and hospital includes;</p> <p>An RN on duty each shift. An extra RN each Thursday for the GP round, and additional RN for a half day each fortnight for medication reconciliation. Each interRAI trained RN also gets a documentation</p>

		<p>day every four to six weeks.</p> <p>Caregivers include;</p> <p>For the AM: A senior caregiver/enrolled nurse for a short shift each day and six caregivers (two long-shifts and two short).</p> <p>For the PM; five caregivers (one long and four short). Staff interviewed stated that the short shifts that end at 9.00 pm leave the service short staffed.</p> <p>Night; one caregiver.</p> <p>Interviews with residents all confirmed that staffing numbers were appropriate. Staff interviewed stated that they do not always have sufficient staffing levels.</p>
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 were appropriate to the service type. Residents entering the service had all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files were located in the nurses' station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries were legible, dated and signed by the relevant staff member.
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 transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.
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.	FA	<p>Twelve medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. The service uses a paper-based medication management system for all residents. The medication charts reviewed identified that all medication was signed for by the GP and that the GP had seen and reviewed the resident at least three-monthly.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses interviewed could describe their role regarding medication administration and were observed on day of audit correctly administering. Medications are pre-packaged by the pharmacy. Staff report that all medications are checked on delivery against the medication chart, which is documented.</p>

		<p>Standing orders are in use and contraindications for each medication are documented. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperature is recorded regularly and is within the acceptable ranges.</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 component of service delivery.	FA	<p>All meals at Homestead are prepared and cooked on-site. There is a four-weekly seasonal menu, which was reviewed by a dietitian in August 2017. The temperature of the food is checked before leaving the kitchen. The kitchen staff were aware of all residents' special dietary requirements on the day of audit. The cook visits the sites most days and if residents are losing weight or not enjoying meals she discusses with them, or their families, what food they would prefer, and this is provided. Individual resident likes and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents interviewed were very complimentary about the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier. Fridge temperatures are recorded for the fridges in each resident dining/servery area. The kitchen has been recently renovated, with new fridges and freezers, however, the dining room is still in need of repair due to earthquake damage (link 1.4.2).</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	<p>The reason for declining service entry to prospective residents to the service is recorded. Should this occur, the manager stated it would be communicated to the potential resident/family and the appropriate referrer. Potential residents would only be declined if there were no beds available or if they could not meet the service requirements.</p>
Standard 1.3.4: Assessment Consumers' needs, support	FA	<p>Six of six files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Six of six files sampled contained appropriate assessment tools that were completed and reviewed at least six</p>

requirements, and preferences are gathered and recorded in a timely manner.		monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. Four of nine registered nurses are interRAI trained. InterRAI assessments have been completed for all long-term residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Two of six care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement. Four care plans reviewed had been evaluated but unclear what interventions were current and what was obsolete. The service has adopted a new care plan format, which was evident in two of the care plans reviewed. These were clear, and resident focused. The service is transitioning all care plans to the new format. Staff interviewed were able to describe resident interventions correctly. The service has a number of care plans in use (e.g., nursing care plan, short-term care plan, and wound care plan). The interRAI assessment process informs the development of the resident's care plan. Residents interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>A written record of each resident's progress is documented. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation.</p> <p>In three of the six files reviewed, short-term care plans were evidenced following a change in health condition and linked to the LTCP (link 1.3.5.2). There was evidence in the files sampled of referral for specialist advice. Action plans documented by allied health practitioners had been implemented or documented in the nursing care plans.</p> <p>Dressing supplies are available. Wound care documentation was reviewed for 15 residents with 12 minor wounds (one resident had two wounds) and one resident with a pressure injury, grade 2 (healed but the plan remains in place to ensure regular checking). Wound care assessments, plans and reviews including photographs were documented for all wounds and there was evidence of GP involvement in the management of wounds.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses could describe access to continence specialist input as required.</p> <p>Monitoring forms are in use by the registered nurses. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring and turning charts.</p>

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	<p>The diversional therapist works 30 to 40 hours per week. A wide range of activities addressing the abilities and needs of different residents (rest home and hospital) are offered and the attendance rate is high with residents of different abilities being supported to enthusiastically join in the activities.</p> <p>A wide range of group activities are offered, with many at the suggestion of residents. There is also significant engagement with the community including outings to clubs and concerts and a variety of groups and individuals from children to older people visit the service.</p> <p>Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing.</p> <p>On admission, the diversional therapist completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>Resident's interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status, however, four of the six care plans reviewed were overcrowded with updates making it difficult to understand (link 1.3.5.2). There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family are involved as appropriate when a referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance.

<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>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.</p> <p>Chemicals were secured in designated locked cupboards. Chemicals were labelled, and safety datasheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties.</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>	PA Low	<p>The building has a current building warrant of fitness which expires on 1 June 2018. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. There are outside areas with seating, tables and shaded areas that are easily accessible. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The kitchen area has recently been extensively renovated, with new equipment. The dining room is still in need of repair due to earthquake damage.</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>The facility has sufficient communal bathrooms and toilets, including visitor toilets. All resident rooms have an ensuite toilet and hand basin. The ensuites and communal toilet facilities have privacy locks. Residents interviewed confirmed their privacy is assured when staff are undertaking personal care.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms, and this has occurred.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large communal lounge and dining area that is well used and several smaller areas including a library area. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. The main lounge is used for activities and a specific area for the hairdresser. The outdoor courtyards are also used for activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Dedicated cleaning staff are rostered on seven days per week. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme.</p> <p>The laundry is all completed on-site, and dedicated laundry staff are rostered on seven days per week. Laundry and cleaning staff interviewed advised that they had received training in chemical safety, infection control and waste management.</p> <p>Cleaning products and laundry products are well labelled and kept in securely locked cupboards and chemical safety data guidelines are available.</p> <p>The laundry and cleaning service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Residents interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. There is a first aid trained staff member on every shift. There is a New Zealand Fire Service approved evacuation scheme with a covering letter dated 26 August 2000. The last trial evacuation was held on 21 November 2017. The facility is powered by electricity and gas. There is an alternative energy supply in the event of the main supplies failing. The facility also has a gas BBQ, torches, and extra emergency 'silver' blankets. Emergency water is available on-site in boxed containers, enough for three litres per day for three days per resident. Emergency food supplies sufficient for three days, are kept in the kitchen. The facility has emergency lighting that lasts for four hours. The service has a defibrillator which is kept in the reception area.</p> <p>There is an appropriate 'call system' available to summon assistance when required. Residents have access to a call bell in their rooms and in communal areas. The system is monitored from an electronic box in the nurses' station. The internal audit programme monitors call bells every two months. There are procedures in place to ensure the safety and security of the residents at night.</p>

		The security arrangements in place include locked doors and closed windows once dark and a security check is done at the midnight handover of caregivers. Homestead Ilam has a critical incident plan (i.e., a major incident and health emergency plan) that covers how services are provided in a civil defence or other emergencies. The service holds adequate pandemic and outbreak supplies on-site and a civil defence emergency kit.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The clinical nurse manager is the infection control coordinator (with the acting clinical nurse manager supporting the role in the interim). The infection control coordinators job description has identified delegated responsibilities for infection control within the service. The infection control coordinator provides a report to the quality team and staff. Infection data is benchmarked via an external company. The infection control programme has been reviewed annually. Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents and staff. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator manages infection control with support from the quality coordinator. The infection control coordinator has attended external education in the last year. The infection control coordinator has access to infection control personnel within the district health board, infection control specialist, laboratory services and the GP.
Standard 3.3: Policies and procedures	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of

<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>staff. The policies have been purchased from a contractor and evidence regular reviews.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. An infection control specialist has provided infection control education. Staff receive education on orientation and one-on-one training as required.</p> <p>Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.</p>
<p>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.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections were entered onto a monthly facility infection summary and staff were informed. This data is monitored and evaluated three monthly and annually. A flu outbreak in 2015 was appropriately managed, with notification to the relevant authority.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with a restraint and four residents using enablers (lap belts and bed rails). The file for two of the residents using enablers reflects a restraint/enabler assessment and voluntary consent by the resident (link to 1.2.7.5 for lack of training in challenging behaviour).</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)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The service has a documented orientation process and orientation templates. Staff interviewed all stated they had been orientated to the service and had been ‘buddied’ when they commenced employment. Orientation documentation was not fully completed. The service was aware of this issue and was able to explain the process they are implementing for new employees	Of the seven staff files reviewed; two staff had no documented orientation (one RN and one DT) and two staff did not have an orientation completed in a timely manner, one RN was employed November and one caregiver employed October 2017, both had incomplete orientation documentation.	Ensure that all staff have a documented orientation when they join the service and that orientations are completed. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and	PA Low	There is a training programme in place for 2017 and 2018. Staff interviewed all agreed that the service provides both formal and informal training and teaching sessions. A review of the last two years did not evidence that all compulsory subjects had been provided and attendance at training was low at times.	(i)Not all compulsory education has been provided, examples include privacy and sexuality and also challenging behaviour. (ii) Attendance at training has been low with less than 50% attendance numbers at 25% of training session viewed.	(i)Ensure that all compulsory subjects are included in the training plan. (ii) Ensure that staff are provided with the information needed

effective services to consumers.				to ensure best practice. 60 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	The service has a staffing roster in place, residents stated they are well cared for. Registered staff report that there are enough RNs. All staff interviewed felt that the caregiver staffing was often low.	Discussion with both senior care staff and caregivers evidenced that staff are concerned regarding staffing levels; particularly at the weekends. A review of the staffing roster and staff on duty over four consecutive weekends evidenced that; over four weekends (16-day shifts) four shifts were a caregiver short. It was also noted that for the last two weeks one staff member had worked six shifts then five the next week (with no break in-between) one staff member had undertaken double shifts for seven days. Staff also stated that all staff including the RNs always helped and felt the team were working together. From 9.00 pm until the following AM shift there is one RN and one caregiver on duty for 10 rest home and 25 hospital residents. Staff report that currently they struggle from 9 – 11pm, as the RN often has RN roles to perform and some residents still need a high level of assistance after 9.00 pm. Since the draft report, the provider has stated that further caregiver hours have been put in place.	Review the staffing and ensure there are enough staff to fully staff the roster and adjust the roster depending on the needs of residents. 30 days
Criterion 1.3.5.2	PA	Care plans were in place in all six resident files	Four of six care plans (three rest home	Ensure that care

<p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>Moderate</p>	<p>reviewed. There was documented evidence that care plans had been updated with changes to care, however, interventions that were no longer current had not been crossed and signed out. Care plans were overcrowded with old and new interventions and therefore difficult to follow.</p>	<p>and one hospital) had been updated, but obsolete interventions had not always been crossed and signed out as resolved or not current.</p>	<p>plans contain up-to-date information and obsolete interventions are crossed out. 60 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>Homestead Ilam experienced significant damage during the February 2011 earthquakes in Canterbury. Several structural engineering reports document that the building is safe to occupy until repairs occur, but the damage resulted in the requirement for significant repairs to return the building to a suitable facility for aged care residents. Since the previous audit the new owners have completed a number of environmental improvements. The kitchen has been refurbished with new equipment and set up, new floor and ceiling repairs done. The laundry floor and ceiling changed. The corridors, lounges, rooms have been refurbished with paint and new carpet. A new office built downstairs. New equipment has been purchased including (but not limited to) full hoist, weighing scale, and DT equipment.</p>	<p>The dining area walls and ceiling and pole supporting beam in the dining room remain in situ and repairs are still needed.</p>	<p>Ensure the dining room plan for repair/refurbishment is implemented. 180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.