

Riverleigh Care Limited - Riverleigh Residential Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Riverleigh Care Limited
Premises audited:	Riverleigh Residential Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 22 August 2018 End date: 23 August 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	41

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.

General overview of the audit

Riverleigh Residential Care is currently owned and operated by TerraNova Homes and Care Ltd and provides rest home, hospital and residential disability – physical level care for up to 64 residents. On the day of audit, there were 41 residents. The residents and family members commented positively on the care and services provided.

This provisional audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management and staff.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse (RN) and has been in this position for three and a half years. The facility manager is supported by a clinical coordinator, who has been in the role for one year and has over 28 years' experience as an RN.

The prospective new owner does not have any recent work experience in the aged care sector, however the current owner will transition the prospective new owner into the aged care sector, providing support through the process for at least a three-month period and longer if required. The prospective owner intends to maintain the existing quality management system, and policies and procedures. A transition plan and business plan has been developed. The manager and staff will remain in their roles to support the new owner.

Improvements are required around; complaints documentation, training, medication documentation, the admission agreement and IC coordinator training.

Consumer rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents interviewed spoke positively about care provided at Riverleigh Care. Complaints processes are implemented, and complaints and concerns are managed. Annual staff training reinforces a sound understanding of resident's rights and their ability to make choices.

Organisational management

Riverleigh has a documented quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, restraint, review of risk and monitoring of health and safety including hazard management. There is a monthly staff meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times.

Continuum of service delivery

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts (reviewed) were reviewed at least three-monthly by the general practitioner.

The two activities assistants provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

Restraint minimisation and safe practice

There are policies and procedures to follow in the event that restraint or enablers were required. On the day of the audit there was one resident with a restraint (bedrails) and eight residents using enablers (all bed rails). A registered nurse is the restraint coordinator. Restraint education is included in the two-yearly training programme.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	5	0	0	0
Criteria	0	96	0	5	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Advocacy pamphlets and the Code of Rights are clearly displayed at the facility entrance. Five residents interviewed (one younger person disabled, two hospital and two rest home) and two-family members (one hospital and one rest home) confirmed that information has been provided around the Code of Rights. There is a resident rights policy in place. Discussion with three caregivers, two registered nurses and an activities coordinator identified that they were aware of the Code of Rights and could describe the key principles.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent</p>

		<p>processes.</p> <p>Residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>Six long-term and one short-term resident file reviewed had signed admission agreements (link 1.3.1.4).</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code and advocacy pamphlets on entry. Resident advocates are identified on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents confirmed their understanding of the availability of advocacy services. Caregivers interviewed were aware of the resident's right to advocacy services and how to access the information.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. Residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed visiting the home. Residents verified that they have been supported and encouraged to remain involved in the community. Community groups visit the home as part of the activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the FM in an electronic database. The service has not always documented timeframes that complaint responses were completed or that the complainant has been notified of the outcome following a complaint. There have been 15 complaints made since the surveillance audit in February 2018, including one via the DHB which is still in progress. Residents interviewed advised that they are aware of the complaints procedure. Staff interviewed could describe the</p>

		complaints process (link 1.2.7.5).
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome information folder that includes information about the Code of Rights. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The facility manager (FM) is available to discuss concerns or complaints with residents and families at any time. Residents interviewed stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</p> <p>The prospective new owner understands the Consumer Rights. The prospective owner confirmed, that he will ensure the code of rights information is provided as part of pre-admission information packs, including information on advocacy and 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>	FA	<p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity was maintained. Staff interviewed could describe how they maintain resident privacy. Staff sign standards of conduct, which include privacy, on employment. The FM is the privacy officer and has an open-door policy. Residents interviewed confirmed they have freedom of choice and their values and beliefs are respected. Care plans reviewed identified values & beliefs are documented. Staff interviewed, and documentation reviewed identified there were no incidences of abuse & neglect and staff could describe definitions of abuse & neglect and their responsibilities for reporting.</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>There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The service has established a link with local iwi who provides advice for staff and advocacy for Māori. On the day</p>

		of the audit there was one resident that identified as Māori. Staff interviewed reported they were aware of specific cultural requirements for Māori residents.
<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	The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Staff attended cultural awareness training in December 2017 (link 1.2.7.5). Residents are supported to maintain their spiritual needs with regular on-site church services and attending other community groups as desired.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The staff employment process includes the signing of a standard of conduct. Professional boundaries are defined in job descriptions. Staff are observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with three caregivers and two RNs could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The service has a range of comprehensive and current clinical policies available to provide a good level of assurance that it is adhering to relevant standards. Staff interviewed had a sound understanding of the principles of aged care and stated that they feel supported by management. Evidence was sighted in residents' records of regular input from health providers such as the hospice, diabetes nurse specialist, wound care specialist, community dietitians, services for older people and mental health services. The clinical coordinator advised that these specialist providers were available as resources if additional expertise was required. All residents interviewed spoke positively about the care provided.

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is an open disclosure policy. Accident/incident forms and electronic records of incidents have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed for July/August 2018 identified that family were kept informed. Residents and family interviewed, confirmed on interview that the staff and management are approachable and available. Staff were observed communicating effectively with residents. The information pack is available in large print and advised that this can be read to residents.</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>	<p>FA</p>	<p>Riverleigh Residential Care provides rest home, hospital and residential disability – physical level care for up to 64 residents. On the day of audit, there were 41 residents in total, 18 residents requiring rest home level care, including one resident on respite, two on long-term support chronic health condition (LTS-CHC) contracts and one on mental health funding. There were 23 residents requiring hospital level care, including, one resident on a LTS-CHC contract and six younger persons with disabilities (YPD) residents. All of the beds are designated for dual use as either rest home or hospital level.</p> <p>The service is one of three facilities owned and operated by TerraNova Homes and Care Ltd. The company has established systems, policies and procedures for providing a consistent approach to service delivery in all their homes. There are policies and procedures appropriate for service delivery including the specific needs of younger people. The organisation has a clearly defined scope, direction and goals documented in the service marketing literature and the 2018/2019 business plan and quality and risk plan.</p> <p>The facility is managed by an experienced and suitably qualified manager who is a registered nurse (RN) and has been in this position for three and a half years. The facility manager is supported by a clinical coordinator, who has been in the role for one year and has over 28 years' experience as an RN and five years' experience in a clinical lead role. The clinical coordinator is responsible for oversight</p>

		<p>of the clinical service in the facility. Support is provided by the Executive Director and Clinical Quality and Risk advisor from TerraNova head office.</p> <p>The management team are supported by executive management during weekly teleconferences and regular forums. Information about operations including clinical data, occupancy, staffing and finances is reported to head office each month. This provides targets for performance.</p> <p>The facility manager has completed more than eight hours of training in the last year relating to the management of an aged care facility by attending regular professional development and industry conferences.</p> <p>The prospective new owner advised she has been an entrepreneur in France for 20 years, owns two hotels and has an interest in a family champagne business. The prospective new owner does not have any recent work experience in the aged care sector, however the current owner will transition the prospective new owner into the aged care sector, providing support through the process for at least a three-month period and longer if required. The facility manager will continue to be employed by the prospective new owner. The clinical coordinator has resigned from her role and the service has appointed a senior RN to this role. The prospective owner intends to contact an aged care contractor to provide additional mentor, policy and procedure support.</p> <p>The expected settlement date is not yet confirmed; however, the prospective owner has contacted both the MOH and the DHB and both are aware of the pending change of ownership. The transition plan confirms there will be no changes to clinical systems, policies or procedures in the short-term, however both the current ownership and prospective owner are planning further involvement with an external contractor.</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</p>	<p>FA</p>	<p>During the temporary absence of the manager, the clinical coordinator is the acting manager with the support from the RNs. The same arrangement will continue with the change of owner.</p>

provision of timely, appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>TerraNova has quality and risk management systems implemented across its facilities. A risk management system is in place. All incidents are reported on an electronic documentation system (People Point) and reviewed by the clinical coordinator on a daily basis. Incidents are also able to be reviewed in detail by the facility manager, executive director (ED) and clinical quality & risk (CQ&R) advisor. The online reporting system gives a thorough analysis and is managed by the TerraNova CQ&R advisor who supports the managers at Riverleigh Residential Care to further analyse the data and introduce corrective actions where needed. Interviews with the staff reflect their understanding of the quality and risk management systems.</p> <p>TerraNova's policies, procedures and relevant forms are available both in hard copy and online. Updated documents are released/supplied to the facility. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): resident falls, infection rates, skin tears, complaints received, restraint use, pressure injuries and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Corrective actions are developed when service shortfalls are identified. Quality and risk data, including trends in data and benchmarked results are discussed in the monthly full staff and clinical meetings. Falls prevention strategies are in place.</p> <p>An annual resident satisfaction survey is completed, the last one completed in April last year identified a 71.25% overall score. A survey for this year is due to be distributed.</p> <p>Three steering groups at an organisational level have been implemented, including a restraint, health and safety, and infection control group. A representative from Riverleigh Residential Care attends each of the organisational steering groups. The health and safety representative has attended specific health and safety training. There is organisational three-monthly health and safety meetings, with</p>

		<p>a focus on reducing hazards and promoting safe work habits amongst employees. Hazards are reported on an electronic database. The hazard register had been reviewed annually at head office level and is discussed at monthly staff meetings. The health and safety representative reports to the staff meeting on any health and safety issues and hazards.</p> <p>The prospective new owner has confirmed that there will be no changes to the current quality and risk management system or policies and procedures initially, however he is considering input from contractors with comprehensive aged care programmes for the future. The current ownership and management team will be available to mentor the prospective new owner to the quality risk system.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. Twelve incident forms reviewed from July/August 2018 evidenced that appropriate clinical care is provided following an incident. Reports were completed, and family notified as appropriate. All incident forms are signed off by the CC or FM. The caregivers interviewed, could discuss the incident reporting process. The clinical coordinator collects incident forms, investigates and reviews, and implements corrective actions as required. Discussions with the facility manager confirmed that she is aware of the requirement to notify relevant authorities in relation to essential notifications. Evidence of this was sighted for two section 31 notifications made this year, one for stage four pressure injury and one for a resident who wandered, with police notification.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one clinical coordinator, two RNs, three caregivers, one chef and one activities coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that</p>

		<p>provides new staff with relevant information for safe work practice. An induction booklet for caregivers aligns with foundations level two and they have 90 days to complete. On completion of this orientation, they have effectively attained their first national certificates. From this, they are then able to continue with core competencies level-three, unit standards.</p> <p>There is an annual education planner in place for 2018 and the planner for 2017 has been completed. A competency programme is in place with different requirements according to work type. Core competencies are completed annually, and a record of completion is maintained (as evidenced in the electronic database). Competencies include (but not limited to): fire safety, medication, manual handling, controlled drug checking, use of restraint, standard precautions and wound care. Staff training has included sessions on privacy/dignity and spirituality but has not provided training for specific needs for the younger disabled person. A review of all training evidences that some subjects have a low attendance rate.</p> <p>Three out of eight permanent RNs and the clinical coordinator are interRAI trained. Specific training is provided regularly for RNs, (ie, wound care/skin tear training in November 2017 and skin integrity/pressure area training in August 2018). Registered nurses are also able to attend external training sessions provided by the local DHB.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Adequate RN cover is provided 24 hours a day, seven days a week. The FM (RN) and clinical coordinator (CC) works Mon/Tues/Thurs and Friday. The FM, CC and senior RN provide on call cover rotating over three weeks for any operational and clinical issues. The local general practice service also provides after-hours phone advice if required. Interviews with caregivers and residents identified that staffing is adequate to meet the needs of residents. Staff reported that management are supportive of staffing needs and</p>

		<p>assist when required.</p> <p>The service is divided into two wings.</p> <p>Registered nurse cover across the facility includes a RN on morning shift. On afternoon shift, there is a RN who does long shift (8hrs) and a RN who works a short shift (5hrs) There is a RN on night shift.</p> <p>In the upstairs Tui wing (27 residents in total, 17 rest home and 10 hospital including three YPD) there are three caregivers (two long-shift and one short-shift) in the morning shift, two caregivers (two long-shift) in the afternoon shift and one caregiver on the night shift.</p> <p>In the downstairs Kiwi wing (14 residents in total, one rest home and 13 hospital including three YPD) there are three caregivers (two long-shift and one short-shift) in the morning shift, three caregivers (two long-shift and one short-shift) in the afternoon shift and one caregiver on the night shift.</p> <p>Riverleigh also rosters support staff as follows: A physio assistant 3 and ½ hrs hours a day Monday to Friday, an activities coordinator from 12.00 pm to 4.30 pm and a recreational assistant from 9.00 am to 3.00 pm. There are two cleaners employed from 8.00 am to 2.00 pm.</p> <p>The prospective owner stated there will be no changes to staff who will transfer to the new owner on the date of settlement.</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>	<p>FA</p>	<p>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Personal resident information is kept confidential both electronically and in resident files and are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</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</p>	<p>PA Low</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for</p>

services has been identified.		families and residents prior to admission or on entry to the service. Admission agreements reviewed (for long-term residents) did not align with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.
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.	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs and occasionally some caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There was a resident self-medicating on the day of audit. The resident had a locked drawer in their room and assessments and three-monthly reviews documented. Fourteen electronic medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round. The effectiveness of 'as needed' medication is not always documented.
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	There is an equipped commercial kitchen, on-site. Most of the food is prepared and cooked on-site. All kitchen staff have completed food safety training. The menu has been approved by a dietitian. A food services manual is available to ensure that all stages of food delivery

		<p>to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents. All food in the freezer and fridge was labelled and dated. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for and currently the kitchen is catering for a resident who likes vegetable curries. Alternative meals can be accommodated if needed. Residents (including one YPD) and relatives interviewed, reported satisfaction with food choices and meals, which were well presented.</p>
<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.</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>An initial assessment, including a clinical risk assessment and relevant risk assessment tools and care plan are completed on admission to the service. This care plan is used for short-term admissions. Long-term residents have risk assessments completed six-monthly with the interRAI assessment or earlier due to health changes. InterRAI assessments reviewed, were completed within 21 days of admission and six-monthly thereafter. Resident needs and supports were identified through available information such as discharge summaries, interRAI, medical notes and in consultation with significant others and included in the long-term care plans.</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>Resident care plans reviewed were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files. The resident on respite care (short-term resident) had all identified needs included in the respite care plan and the YPD resident had interventions documented in the care plan that were specific to their needs as a younger person as well as promoting independence and access to the community. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.</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>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the resident's electronic file. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds. Ten wounds were documented on the wound log, including three grade-two pressure injuries. Four wounds were minor skin tears, more complex wounds, including the pressure injuries, a chronic wound and erythema all had regular photos documenting wound progress.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Monitoring forms are documented and completed as</p>

		needed.
<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>	FA	<p>The service employs an activities coordinator and recreational assistant, who between them, provide activities Monday to Friday. The activity plan also identifies activities for the weekend for caregivers to follow. The programme is integrated to meet the physical and psychosocial well-being of the residents. The programme includes new activities when requested by residents and is varied. There are regular outings into the community. There are clubs for residents including; the scrabble club, gardening club, card club and blokes shed.</p> <p>One-on-one activities such as reading, and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The specific needs of the younger resident are documented and addressed on a one-to-one basis, with card clubs and bingo a firm favourite according to a younger resident interviewed.</p> <p>An activities assessment is completed on admission. Individual activity plans were seen in long-term resident files. The service receives feedback and suggestions for the programme through monthly resident meetings and direct feedback from residents and families. There is a van and some of the younger residents attend outside community groups.</p> <p>Residents interviewed spoke very positively about the varied activities programme which they have input into.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes. Care plans had been updated to reflect the evaluations and included progress towards meeting goals. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are</p>

		documented within the progress notes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
<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	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 24 September 2018. The maintenance person undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours.</p> <p>The service is on two levels. There are 33 resident rooms upstairs, two of which are in the process of extensive renovations and one in the process of repainting. There are 24 rooms downstairs, one of which is in the process of being repainted. There are two double rooms downstairs and one upstairs and privacy curtains are in place for all double rooms. There is a lift between floors. The lift has a documented lift inspection dated 24 July 2017. The facility has wide corridors with sufficient space for residents to safely mobilise using</p>

		<p>mobility aids. There is safe access to the outdoor areas. Seating and shade is provided.</p> <p>The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The prospective owner stated there will be no changes initially to the environment.</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>A number of bedrooms have either full ensuites or ensuites consisting of a wash hand basin and a toilet. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access. Younger residents with a physical disability have full ensuites and reported easy access to these.</p> <p>Appropriately secured and approved handrails are provided, and other equipment is available to promote resident's independence.</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>There is adequate personal space provided for residents and staff to move around within the bedrooms safely. There is a mix of single and double rooms. The three double rooms currently provide single accommodation. Residents, including younger residents with a physical disability, spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheelchairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are several areas for residents to frequent for activities, dining, relaxing and for privacy, including a lounge and dining room downstairs and a dining room and library (small lounge) upstairs. These areas are easily accessed by residents including younger residents with a physical disability and staff. Residents confirmed this. Furniture is appropriate to the setting and arranged in a manner which</p>

		enables residents to mobilise freely.
<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>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff. All laundry is completed on-site. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaners' trolleys are stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments.</p> <p>Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available always. All RNs hold a current first aid certificate. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells near.</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</p>	FA	<p>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central computer system. The residents and family interviewed</p>

temperature.		confirmed temperatures are comfortable.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The clinical coordinator (registered nurse) is the designated infection control coordinator with support from the manager and the head office team. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has external support from the clinical quality and risk advisor at head office and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	PA Low	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is

		appropriate to their needs and this is documented in their medical records. The infection control coordinator has not completed external training to support her role.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator (clinical coordinator) collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility, including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. Infection rates are benchmarked within TerraNova and externally. There have been no outbreaks since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. On the day of the audit there was one resident with a restraint (bedrails) and eight residents using enablers (all bed rails). Three files reviewed evidenced enabler assessments and current care plans that identified risks associated with the use of the enabler. The use of the enabler was voluntary. Restraint education is included in the two-yearly training programme and last occurred in June 2018.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.

<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>	<p>FA</p>	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau in the three files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the one restraint file and two enabler files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is put in place only where it is clinically indicated and justified and approval processes. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the restraint file reviewed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the restraint files reviewed, evaluations had been completed with the resident, family/whānau, and the restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</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>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly staff and clinical meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The service maintains an on-line complaints and compliments register. All complaints are documented. A review of 15 complaints identified that timeframes of initial responses were not documented and the register and supporting documentation does not evidence that all complainants have been notified of outcomes	The complaints register does not reflect that all complaints meet required timeframes under Right 10 of the code. Timeframes of initial responses were not documented and the register and supporting documentation does not evidence that all complainants have been notified of outcomes.	<p>Ensure the complaints register records all dates of initial response and communication of outcomes.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	There is a two-yearly education plan in place that includes all required education as part of these standards. Individual training is recorded in an electronic database. Not all specific compulsory education had been completed in the two-yearly education plan and	<p>i) Staff have not received specific training to meet the needs of the YPD residents.</p> <p>ii) Staff attendance at compulsory in-service sessions is 50% or below for continence, pressure injury prevention, cultural and spirituality and falls</p>	<p>Ensure staff attend compulsory training as scheduled.</p> <p>90 days</p>

		attendance is low.	prevention.	
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	All permanent residents have a signed admission agreement. Two newer residents have an up to date admission agreement. This agreement does not comply with all aspects of the ARRC agreement.	The current admission agreement does not comply with section D13.1 for the ARRC agreement (repayment times).	<p>Ensure the current admission agreement meets the requirements of the ARRC agreement.</p> <p>90 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	The service uses an electronic medication system. All fourteen medication charts included verified prescriptions and medications had been signed as given according the regular medication charts and 'as needed' prescriptions. Not all 'as needed' medication documented the effectiveness of the medication given.	Of the fourteen charts, all included examples of 'as needed' medication as having been given. Four did not document the effectiveness of the medication including; one for midazolam, one for strong analgesia, one for paracetamol and one for an enema.	<p>Ensure that the effectiveness of 'as needed' medication is documented.</p> <p>60 days</p>
<p>Criterion 3.4.1</p> <p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.</p>	PA Low	The IC coordinator provides training to staff. The infection control coordinator has not completed external training to support her role.	The infection control coordinator has not completed external training to support her role	<p>Ensure external training is completed by the IC coordinator</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.