

Elms Court Rest Home Limited - Elms Court Rest Home

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: Elms Court Resthome Limited

Premises audited: Elms Court Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 11 July 2018 End date: 11 July 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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

Elms Court Rest Home is privately owned and operated, and provides care for up to 19 residents requiring rest home level care. On the day of the audit there were 19 residents.

The service is managed by a manager/owner who has worked at the facility for seven years prior to becoming manager/owner three and a half years ago. The manager/owner is supported by a part time assistant manager and clinical manager/RN. Residents and families interviewed were complimentary of the care and support provided. Staff turnover remains low.

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

This certification audit identified area for improvement relating to documented interventions.

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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The staff at Elms Court Rest Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. There is a complaint's register and residents and families are aware of the complaints process.

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.		Standards applicable to this service fully attained.
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There is a documented quality and risk programme. Progress with the quality and risk management programme has been monitored through the quality improvement meetings and staff meetings. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is a current business plan in place. Resident/relative meetings are held monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an admission package available prior to or on entry to the service. The clinical manager/RN is responsible for each stage of service provision. The clinical manager/RN assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and were evaluated at least six monthly. Medication policies reflect legislative requirements and guidelines. The clinical manager/RN and senior care partners (caregivers) responsible for administration of medicines complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three monthly by the general practitioner. The lifestyle coordinator provides and implements an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational preferences of the residents. Residents' food preferences and dietary requirements are identified at admission and all meals and baking 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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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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. There are adequate communal toilet/shower rooms. 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. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Elms Court Rest Home has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training in restraint minimisation and challenging behaviour management.

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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. 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	44	0	1	0	0	0
Criteria	0	92	0	1	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>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with three care staff (two care partners and one lifestyle coordinator) confirmed their familiarity with the Code. Six residents and two-family members interviewed, confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Permissions granted for general consents are included in the admission agreement as sighted in five of five rest home files, including one resident under 65 years on the LTS-CHC contract and one younger person under Ministry of Health (MOH) funding. Consent forms are signed for any specific procedures such as the influenza vaccine. Care partners interviewed confirmed consent is obtained when delivering cares. Advance directives also identified the resident resuscitation status and signed by the resident (if appropriate) and the GP. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate. Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Five admission agreements were sighted.</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>Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.</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>	FA	<p>The complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. The residents and families interviewed were aware of the complaints process and to whom they should direct complaints. Complaint forms are visible at the entrance of the facility. A complaints procedure is provided to residents within the information pack at entry. A complaints register is maintained. Seven complaints have been received at Elms Court Rest Home since the last audit, five made in 2017 and two received in 2018 year to date. The complaints reviewed have been acknowledged and investigated. Complainants are informed of the outcome and satisfaction of the outcome noted</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code and advocacy pamphlets are located at the main entrance of the service. On admission the manager/owner or clinical manager/RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are informed about the Code.</p>
<p>Standard 1.1.3: Independence,</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident</p>

<p>Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>records, resident's privacy and dignity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Staff receive training on abuse and neglect, which was last completed in April 2018.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were no residents that identified as Māori. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training on cultural safety and Treaty of Waitangi, which was last completed in October 2017.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The manager/owner is responsible for coordinating the internal audit programme. Bi-monthly staff and three-monthly quality/management meetings and three-monthly residents' meetings are conducted. Residents and relatives interviewed spoke</p>

		positively about the care and support provided. Staff interviewed stated that they feel supported by management.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Residents and relatives interviewed confirmed that management and staff are approachable and available. Twelve incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any incidents/accidents. Families are invited to attend the three monthly resident/family meeting. The service has policies and procedures available for access to interpreter services for residents (and their family). 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>Elms Court Rest Home is privately owned and operated, and provides care for up to 19 residents requiring rest home level care. On the day of the audit, there were 19 residents in total, including three residents on younger persons with disability (YPD) contracts (one was under MOH funding) and two residents on long-term support chronic health conditions (LTSCHC) contracts. All other residents were under the aged related residential care (ARRC) contract.</p> <p>The service is managed by a manager/owner who is experienced in the industry and has worked at the facility for four years prior to becoming manager/owner three and a half years ago. The manager/owner has previously worked in the social service area. The manager/owner is supported by a part time assistant manager and clinical manager/RN, who have both worked at Elms Court for three years.</p> <p>Elms Court has a current 2018/2019 business plan. The business plan identifies all 2017 goals have been achieved. The business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The manager/owner is responsible for the operational and financial aspect of the business.</p> <p>The manager/owner has attended at least eight hours of professional development that relates to managing a rest home including NZ Aged Care Association and quality and risk management training courses.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The manager/owner reported that in the event of her temporary absence the assistant manager or clinical manager/RN fills the role with support from care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk programme describes Elms Court Rest Homes quality improvement processes. Progress with the quality and risk management programme has been monitored through the three-monthly quality/management meetings. The three-monthly quality/management meetings cover matters arising from the bi-monthly staff and three monthly resident meetings, and health and safety, complaints, accidents/incidents, infection control, internal audits, and survey results and outcomes. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant. Staff interviewed confirmed they are well informed and receive quality and risk management information including accident/incident and infection control data.</p> <p>The internal audit schedule for 2017 has been completed and 2018 is being completed as per schedule. Areas of non-compliance identified at audits have been actioned for improvement. The service has implemented a health and safety management system. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the quality/management meeting. Hazard identification forms and an up-to-date hazard register (last reviewed 19 March 2018) are in place.</p> <p>The service has policies/procedures to support service delivery. The policies have been developed by an aged care consultant and are reviewed and updated two yearly. An annual resident and relative satisfaction survey (June 2018) has been conducted with respondents advising that they are overall very satisfied with the care and service they receive. Falls prevention strategies are in place that includes the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms for the month of May and June 2018 were reviewed. All document timely RN review and follow-up. Neurological observation forms were documented and completed for two unwitnessed falls with potential head injury. There is documented evidence the family had been notified of any incidents. Discussions with the manager/owner confirmed an awareness of the</p>

recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged since the last audit.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Five staff files (one clinical manager/RN, three care partners and one lifestyle coordinator) were reviewed. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. A current practising certificate was sighted for the clinical manager/RN. The service has an orientation programme in place to provide new staff with relevant information for safe work practice.</p> <p>Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The clinical manager/RN and care partners complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. The clinical manager/RN has completed interRAI training and has attended education sessions at the District Health Board (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>	FA	<p>Elms Court has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The manager/owner is on-site from 9.00 am until 4.00 pm Monday to Friday and is on-call 24/7 for any operational issues. There is a clinical manager/RN on-site for 19.5 hours per week or more if required and is also on-call 24/7 for any clinical concerns.</p> <p>The local general practitioner (GP) also provides after hours care if required and the care partners have access to the local ambulance service. There are two care partners on duty in the morning shift, two care partners on duty in the afternoon shift and one care partner on the night shift. Roster shortages or sickness are covered by casual or off duty staff. The care partners and residents interviewed report that there is sufficient staff cover.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in</p>

current, confidential, and accessible when required.		a timely manner.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and rest home care are provided for families and residents prior to admission or on entry to the service. Admission agreements reviewed align with 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 exit 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.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. The clinical manager/RN and senior care partners who administer medications have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart and pack signed in on the electronic medication system (implemented August 2017). All medications are stored safely. Medication fridges are checked weekly and maintained within the acceptable temperature range. Eye drops are dated on opening. There was one resident self-medicating on the day of audit. A self-medication competency had been completed and reviewed three monthly by the RN and GP. Ten medication charts reviewed on the electronic medication system were reviewed and met legislative requirements. All medication charts had photo identification and allergy status documented. Indications for 'as required' medication were documented on the medication charts.
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	FA	All meals and baking are prepared and cooked on-site by the cook/assistant manager Monday to Friday and a weekend cook. All staff have completed food safety training. The food control plan expires 18 April 2019. The four-weekly seasonal menu has been reviewed by a dietitian. Resident dislikes are known and accommodated. Meals are plated and served directly from the kitchen area to residents in the dining room. Residents choose the menu on their birthdays. Fridge temperatures are

<p>of service delivery.</p>		<p>taken daily and freezer temperatures weekly.</p> <p>End cooked food temperatures are taken on all foods daily, and recorded. Perishable foods sighted in the fridge were dated. A maintenance and cleaning schedule is maintained. Dried goods in the pantry are dated and goods are rotated when orders are delivered. Resident meetings along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for any dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>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</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The clinical manager/RN completes an initial assessment and care plan on admission including relevant risk assessment tools. Risk assessments are completed six monthly or earlier due to health changes. InterRAI assessments were completed within 21 days of admission as sighted in three resident files admitted within the last six months. InterRAI assessments have also been completed for one resident under 65 years on the LTS-CHC contract and one younger person under MOH funding. Resident needs and supports are identified through available information such as discharge summaries, assessments, 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 (link 1.3.6.1) and sighted in resident files, for example, infections and wounds and have either resolved or if ongoing transferred to the long term-care plan. 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 demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including gerontology nurse specialist, mental health services for the older person, podiatrist, pharmacist,</p>

		dietitian and diabetes service as required.
<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>	PA Low	<p>When a resident's condition alters, the clinical manager/RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence the family/whānau contact sheet in each resident file that evidences family, were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Changes to resident's health are monitored and identified through ongoing daily assessments. Changes to health are reported to the clinical manager/RN who informs the GP or other allied health specialists. Adequate dressing supplies were sighted.</p> <p>Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for two residents (one skin tear, one lesion and one pressure injury). Short-term care plans were in place for both wounds. There is access to a wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Monitoring forms and short-term care plans provide guidance for the safe delivery of care for short-term needs/supports. There were no interventions for one resident with weight loss and two residents with diagnosis of epilepsy. Blood pressures had not been consistently taken for three residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a lifestyle coordinator with an occupational therapy background. She works 16 hours a week spread over four days a week. Working hours are flexible around resident activities such as outings. The programme included activities such as quizzes, word builders, exercises, walks, art and crafts, baking, music, happy hours and news and views. Care partners implement the weekend programme that includes movies. Residents are supported to attend community events including weekly visits to the Selwyn centre and attending concerts in the community with other rest homes. A company car and taxis are used for outings to art galleries, museums and going to the movies. Church services and communion are held on-site. Volunteers are involved in the programme and visit weekly with one from the men's shed. One-on-one time is spent with residents who choose not to participate in group activities.</p> <p>The lifestyle coordinator meets daily with the younger persons to ensure their individual recreational references are being met. They are offered to join in activities and are supported to maintain their interests/outings for example classic cars, car magazines, car museum visits. There is handyman time where residents assist the handyman in the gardens and enjoy outdoor activities including drives to the dump. A resident social profile is completed on admission. Individual activity plans were seen</p>

		in the resident files. The lifestyle coordinator is involved in the six-monthly review with the clinical manager/RN. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents and relatives interviewed were satisfied with all on-site and community activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes for two of the five files reviewed. Three residents had not been at the service six months. Written evaluations reviewed for the two residents who had been at the service for over six months, identified if the resident goals had been met or unmet. The care plans had been updated with changes identified at the multidisciplinary review or earlier. Family are invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
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	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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	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 a locked area within the facility. Bottles have manufacturer labels. Staff have completed chemical safety training. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.
Standard 1.4.2: Facility	FA	The building has a current building warrant of fitness that expires 1 June 2019. Maintenance is

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>overseen by the manager/owner and the maintenance person (previous owner) is on-site twice a week to address maintenance requests recorded in the maintenance book. The maintenance person also tends to the garden and grounds. There is a planned maintenance programme that includes two yearly testing and tagging of electrical equipment and annual calibrations of resident related equipment such as the chair scales.</p> <p>Essential contractors are available 24 hours. Hot water temperatures in resident areas are monitored monthly and have been maintained below 45 degrees Celsius. The facility corridors have sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and gardens. Seating and shade is provided. The care partners and clinical manager/RN stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is one bedroom with a full ensuite. There are adequate numbers of communal toilets and showers. There are privacy locks in place. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares.</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 are 11 single resident rooms and four double rooms. Residents and relatives consent to sharing a room. There are privacy curtains in place. There is adequate room to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, including the residents own furnishing and adornments.</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</p>	FA	<p>The rest home has a separate dining room with an open plan kitchen. There is a separate large lounge area with seating appropriately placed to allow for group and individual activities. All communal areas are accessible to residents. Care staff assist to transfer residents to communal areas for dining and activities as required. The garden and grounds are easily accessible.</p>

needs.		
<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. All linen and personal clothing is done on-site by care staff. There has been a redesign of the laundry to easily identify the clean/dirty area and allow more space for the folding/sorting and ironing of personal clothing. There is appropriate personal protective wear readily available. The cleaner's trolley is stored in a locked area when not in use. Cleaning schedules are maintained. Internal audits monitor the effectiveness of cleaning and laundry processes. Residents and relatives are satisfied with laundry and cleaning services.</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 in May 2015. 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, with the last fire evacuation drill occurring on 5 April 2018. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (well water supply), blankets and alternate gas cooking (BBQ).</p> <p>There are civil defence and first aid kits available. Emergency equipment is available at the facility. There is a generator available on-site. 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 at all times. The clinical manager/RN holds a current first aid certificate. There is a call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents were provided with adequate natural light and safe ventilation. There are heat pumps in communal areas and wall heaters in resident rooms. The residents and family interviewed confirmed temperatures were comfortable.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>The clinical manager is the infection control coordinator with responsibility of overseeing infection control management for the facility. There is a job description outlining defined responsibilities of the</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.		role. The infection control coordinator provides reports quarterly to the management team and bi-monthly to the staff meeting. The infection control programme is reviewed annually last March 2018. Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.
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 has completed the on-line MOH infection control course May 2018. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator can access support/advice from the infection prevention and control community team and the gerontology nurse specialist, GP, practice nurses and Southern Community laboratory.
Standard 3.3: Policies and procedures 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.	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The policies have been developed by an aged care consultant and outlines a comprehensive range of policies, standards and guidelines and includes responsibilities of the infection control team and training and education of staff.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	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 annually and includes hand hygiene competencies. Infection prevention and control is part of the staff orientation process. Resident education occurs as part of daily activities and cares.
Standard 3.5: Surveillance	FA	Infection surveillance is an integral part of the infection control programme and described in the infection control manual. Monthly infection data is collected for all infections based on signs,

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>symptoms and definition of infection. Short-term care plans are used for infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Meeting minutes with attached monthly infection analysis is available to staff. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Elms Court Rest Home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint free environment. Staff receive training in restraint minimisation and challenging behaviour management.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Residents are weighed monthly or more frequently if weight is of concern, however, there were no interventions for one resident with weight loss. Monitoring forms are used for weight, blood sugar levels, bowel charts, pain, behaviour charts and observations. The GP takes and records blood pressures at three monthly reviews, however, this had not been taken three monthly for three residents. Interventions had not been documented for two residents with history of seizures.</p>	<p>i) There were no interventions for one resident with 2.4kg unintentional weight loss who also has a stage two pressure injury, and ii) the GP had not recorded the three-monthly blood pressures for three residents (one for six months, one for five months and one for seven months) and iii) there were no documented interventions for two residents with history of seizures.</p>	<p>i) Ensure weight loss is identified and managed, ii) ensure blood pressures are recorded at the monthly GP reviews and iii) ensure there are documented interventions for the treatment and management of seizures.</p> <p>90 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.