KVTN Investments Limited

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 Q-Audit 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:	KVTN Investments Limited
Premises audited:	Alexandra Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 September 2018 End date: 18 September 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: 44

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

Alexandra Rest Home is certified to provide rest home level care for up to 45 residents. There have been no changes to governance or management since the previous audit.

This certification audit was conducted to assess ongoing compliance with the Health and Disability Standards and the contracts the service has with the district health board. The audit process included a review of policies and procedures, sampling of resident and staff records, observations, interviews with residents, family, staff, management and a general practitioner (GP).

The audit has resulted in no areas of non-conformance being identified. Continuous improvement ratings have been allocated in regard to adverse event reporting, planned activities and infection prevention and control.

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.

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents on admission to the service and during service delivery. There are opportunities provided to discuss and explain the Code, informed consent and the availability of advocacy services. An advocate is available for the residents and the contact details are displayed.

Services are provided that respect choices, personal privacy, independence, individual needs and dignity of residents. Staff were observed to be interacting with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies.

Residents who identify as Maori have their needs, cultural values and beliefs met. Care is guided by the comprehensive Maori Health Plan. Open disclosure is promoted and confirmed to be effective. Interpreter services are accessible.

The service has close links with a range of specialist health care providers and referrals can be arranged as needed.

One of the two managers is responsible for complaints management. A register is maintained, and complaints followed through have been resolved effectively.

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.		All standards applicable to this service fully attained with some standards exceeded.

Business and quality and risk management plans include the scope, direction, objectives, values and mission statement of the organisation. Monitoring of the services provided is reported to the governing body. There are two experienced and suitably qualified people managing the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified. Policies and procedures are reviewed on a regular basis.

Human resource management is based on current good practice. A systematic approach to identify and deliver ongoing education supports safe practice and service delivery. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and is not accessible to the public.

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.		All standards applicable to this service fully attained with some standards exceeded.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission

Residents' needs are assessed on admission by the registered nurse. All residents' files provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted were consistent with these documents.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

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.

The rest home meets the needs of residents. There is a current building warrant of fitness. Electrical equipment is tested and recorded as required. Communal and individual rooms are maintained at a comfortable temperature.

Waste and hazardous substances are managed effectively. Staff wear protective equipment and clothing when managing chemicals, soiled linen and equipment. Safe storage is available. Products used are monitored for effectiveness. Laundry is partially completed on-site.

Staff are trained in emergency management, use of equipment and supplies and attend regular fire drills. Fire evacuations are regularly practiced. Residents report a timely response to call bells. Security is managed to promote safety.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The service has no restraints or enablers in use. Policies and procedures are in place to maintain a restraint free environment.

Infection prevention and control

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

The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control officer reporting directly to the general manager who is the owner.

There is an infection prevention and control programme which is reviewed annually. An infection control officer is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance.

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	2	43	0	0	0	0	0
Criteria	3	90	0	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (The Code). The Code is included in staff orientation and in the in-service education programme. Residents' rights are upheld by staff (eg, seen knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated understanding and knowledge of the Code when interacting with residents. The residents reported that they understand their rights. The family/whānau reported that residents are treated with respect and dignity.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	Evidence was seen of the consent process for the collection and storage of health information, van outings, use of photography for identification and sharing of information with appropriate agencies, identified next of kin and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and where applicable this is activated, and a copy is retained in the resident's records. The advance directives meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive is used to enable residents to choose and make decisions related

informed consent.		to end of life care. Residents and family/whānau (where appropriate) are included in care decisions with the resident and the general practitioner. Alexandra rest home has a separate pamphlet available 'informed choice and consent' and this is provided in the information pack.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Advocacy information is readily available in brochure format at the entrance to the facility and is provided in the information packs provided on admission. Residents and family/whānau are aware of their right to have a support person. Education is provided from the Nationwide Health and Disability Advocacy Services annually as part of the in-service education plan reviewed. The staff interviewed reported knowledge of residents' rights and advocacy services available in the service and in the community. There is a resident advocate for this service and information is displayed on how to make contact as needed.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents reported they are supported to be able to remain in contact with the community through outings as part of the activities programme provided and family/whānau outings. For any appointments arranged in the community assistance is provided as necessary. Residents are able to have family/whānau and friends visit at any time. The family/whānau interviewed stated they are always welcomed by staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The concerns/complaints and compliments and/or suggestions and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint if needed. The complaints register evidenced four complaints had been received since the previous audit and that action was taken through to an agreed solution and all are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. Each complaint was closed out by the manager. The manager is responsible for complaints management for this organisation. The staff interviewed understood about the complaints process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	A copy of the Code and other information related to rights are provided in the information pack provided on admission to the service. The Code is also displayed in poster and pamphlet form throughout the facility. Opportunities for discussion and clarification relating to the Code are provided to residents and

Consumers are informed of their rights.		their families as confirmed by interview with the clinical staff. Discussions relating to residents' rights and responsibilities takes place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Residents and family/whānau report that the residents are addressed in a respectful manner that upholds their rights. Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and is easily accessible for residents/family/whanau. There is also an independent advocate, who is available to residents and contact information is displayed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choice. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities and community visits with family/whanau. Care plans included documentation related to the resident's abilities and strategies to maximise independence. Records reviewed confirmed that each resident's individual identified needs are incorporated into their care plan. Staff understood the service's policy on abuse and neglect. Training has been provided as per the training records reviewed. Staff had a good understanding of what to do should there be any signs and were well informed about how and who to report to if needed.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi and a family/whānau approach is included. Whanau input and involvement in service delivery and decision making is sought if applicable. Specific health, iwi and food preferences are identified on admission. Tikanga best practice guidelines are adhered to and used by service providers. Maori Health advisors are available if and when needed. Staff interviewed demonstrated an understanding of meeting the needs of the two Maori residents who identify as Maori and the importance of whanau. The staff and whanau interviewed reported that there are no known barriers to Maori accessing the service. One staff member identified as Maori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	The cultural and/or spiritual needs of the resident are provided in consultation with the resident and family as part of the admission process and ongoing assessment. Residents confirmed that they were consulted on their individual culture, values and beliefs and that staff respected these. Ethnic food preferences are identified on admission. The care plan is developed to ensure that care and services

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		required are addressed. Weekly interdenominational church services are held at this facility on a weekly basis. Staff confirmed the need to respect the individual culture, values and beliefs of residents and families. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family/whānau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation/induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative care services and mental health teams as required. The general practitioner (GP) visits the service regularly and confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Other examples of good practice observed during the audit included ongoing quality improvement projects which were sampled. Residents' and family/whānau satisfaction surveys evidenced overall satisfaction with the quality of care and services provided. Staff reported they receive ongoing management support for education and the clinical manager can attend external education and access other professional networks.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family/whānau interviewed stated there were kept well informed about any changes to their /their relatives health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sighted. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code. Handovers are provided between all shifts and there is a communication book in the nurse's office that was reviewed. Access to the district health board interpreter services can be arranged and contact details were accessible. Staff representing different ethnicities are able to translate or interpret if required.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business strategic plan is reviewed annually. There are six goals identified for 2018 to 2019 to strive for and to achieve. The plan described the purpose, values, scope and direction of the organisation. A sample of weekly and monthly reports to the manager was sighted and showed the information required was reported as requested and was followed up appropriately by management. The governing body is KVTN Investments Limited. The service is managed by the two owner/managers (who have owned this facility for seven years) and they are supported by the care manager and a quality assurance administrator. Responsibilities and accountabilities are defined in job descriptions for each role. The managers' interviewed confirmed knowledge of the sector, regulatory and reporting requirements. Both managers maintain currency by attending related business courses and representing the organisation at the aged residential care meetings and conferences as a member. The service holds contracts with two DHBs for up to 45 residents. Respite care (nil residents on the day of the audit), aged residential care - rest home level care (41), mental health (1) and YPDs (under 65years) – DHB contract for long term stay chronic (2). There is one additional resident under the supported accommodation contract. The service meets the needs of the people under the different contracts.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the managers are absent the care manager carries out all the required duties under the delegated authority with support of the administrator/quality assurance manager. During the absence of the care manager a senior registered nurse is available who is experienced in the aged care sector and is able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work effectively.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality	FA	KVTN Investments Limited has ensured that the policies and procedures for Alexandra Rest Home have been reviewed since the previous audit. Policies reviewed cover all necessary aspects of the service and contractual requirements including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. All legislative requirements are effectively met. Any obsolete documents are able to be stored appropriately onsite in a locked dry room. Records can be retrieved as needed. The managers and the care manager interviewed clearly understood the organisation's quality and risk

improvement principles.		management system. The quality and risk system reflects the principles of continuous quality improvement and is understood by staff. This includes for example management team meetings, quality and staff meetings. The quality assurance manager has trained the staff to be involved in the internal auditing system at the required timeframes allocated on the audit schedule developed and implemented. The quality assurance manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The quality assurance manager is the health and safety officer and is fully informed about the Health and Safety at Work Act (2015) and has implemented requirements. Minutes of meetings reviewed include discussion on pressure injuries, restraints, falls complaints, incidents/events, infections, audit results and activities. The care manager collates relevant data, and this is reported to the manager. Relevant corrective actions are developed and implemented to address any shortfall and demonstrated a continuous process of quality improvement is occurring. Resident and family/whānau surveys are completed annually. The outcome of the April survey provided positive comments for all staff and management.
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.	CI	Staff document specific events/incidents on a notification form. The managers and care manager review all forms completed and sign them off. A sample of the forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. A hard copy record of the incident goes directly into the individual resident's record as sighted. Adverse event data is collated, analysed and reported by the administrator/quality assurance/health and safety manager on the electronic incident management system now implemented and this information can be accessed at any time. The electronic records reviewed categorise each incident and they are reported as SAC one (1) to (4) with four being the lowest rating. The total falls per 1000 bed days are averaged and graphs are produced. The graphs also define individual residents and the injuries sustained (if any), if they are hospitalised or not and the date of discharge is recorded if they have been in an inpatient service. Several projects are underway and are proving successful from a health and safety perspective such as the falls prevention programme. Policy and procedures described essential notification reporting requirements. The quality assurance manager advised there have been no notifications of significant events since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. There are policies and procedures available to guide staff. The recruitment process includes reference checks, police checks and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records sighted were maintained by the

accordance with good employment practice and meet the requirements of legislation.		management. Education records were in each record reviewed. Management supported care staff to complete the New Zealand Certificate of Health and Wellbeing Level two within one year of commencement of employment, level three within three years and level 4 within six years. All staff receive training in health and safety and infection prevention and control and this was evidenced in the staff records reviewed. Two registered nurses are interRAI trained and maintain competencies which were sighted. Staff orientation includes all necessary components relevant to each role. Staff reported that they received orientation which prepared them for their role. Staff records reviewed evidenced the completion of orientation and performance appraisals occurred and were current for all staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a staffing rationale policy and process for determining staffing levels and skill mixes to provide safe service provision 24 hours a day seven days a week (24/7) and to meet the requirements of the service contracts with the DHB. The layout of the building is considered along with the number of resident and the acuity of residents. The care manager adjusts staffing levels to meet the needs of the residents on a daily basis. An after-hours roster is in place with staff interviewed reporting that access to advice is available when required. The GP is on call and spoke highly of the staff, the care manager, registered nurse and the senior care staff. Any instructions were always carried out appropriately. The care staff interviewed reported that there were adequate staff and that team work is encouraged. Resident and family/whānau interviewed supported this. Observations and review of the rosters confirmed adequate coverage was provided. Staff were replaced for unplanned and planned absences. At least one staff member has a current first aid certificate on each duty. Certificates were sighted in the staff records sampled.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The interRAI assessments were printed off the electronic system and placed into each record reviewed. Hard copy clinical records were reviewed and those sampled were legible with the name and designations of the person making the entry identifiable. All personal information was accurately completed along with the unique identified national health index (NHI) number being recorded on each individual page. All records were integrated with coloured dividers between each labelled section. Archived records are securely stored on site in a locked room and are readily retrievable if needed. Resident records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.

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 enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the general manager (GM) and the care manager (CM). They are also provided with written information about the service and the admission process. The organisation seeks updated information from NASC, general practitioner (GP) and family/whānau for residents accessing respite care. Family/whānau stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. The service uses its only transfer documentation when transferring to another community agency and the yellow transfer envelope if transferring to the DHB. There is open communication between all services, the resident and the family/whānau. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.
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	The medication management policy is comprehensive and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of audit, using a manual system. Plans are in place to implement an electronic medication system at some stage. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Controlled drugs are stored in separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six-monthly stock checks and accurate records. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three-monthly GP review is recorded on the medicine charts. There were two residents who self-administer their medicines on the days of audit. Documentation is in

		place to verify this is managed in a safe manner. Medication errors are reported to the care manager or RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. All PRNs dispensed, have documentation to verify the effectiveness of the medicine administered. PRN medication requests include indications for use.
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	The food, fluid and nutritional requirements of the residents at Alexandra Rest Home is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu 24 August 2018. A food control plan has been registered with Wellington City Council,15 March 2018 A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance. Evidence of resident satisfaction with meals is verified by resident and family/whānau interviews, sighted satisfaction surveys and resident meeting minutes. There is enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining room is visually appealing clean, warm, light and airy to enhance the eating experience. The residents can choose to eat in the dining room or in their room The main meal at Alexandra Rest Home is served in the evening, with a lighter meal being served at mid-day. Interviews verify this is in line with resident's needs.
Standard 1.3.2: Declining Referral/Entry To Services	FA	Interview with the care manager verified a process exists for informing residents, their family/whānau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer,

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.		resident and their family/whānau or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family/whānau with other options for alternative health care arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission to Alexandra Rest Home, residents have their needs identified through a variety of information sources that include: The NASC agency; other service providers involved with the resident; the resident; family/whānau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom with the resident and/or family/whānau present if requested. Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A multidisciplinary assessment is undertaken yearly. Both RNs are trained in using the interRAI and all residents have been assessed using this tool, at the time of audit.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and describes the required support the resident needs to meet their goals and desired outcomes. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned. Care plans are evaluated six monthly or more frequently as the resident's condition dictate. Interviews and documentation verified resident and family/whānau involvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents is consistent with residents' needs and desired outcomes. Documentation is comprehensive and addresses all areas of resident needs. Interventions are updated in line with residents changing needs. Potential side effects to new medications are documented with the potential alerts to be aware of, such as, a resident commenced on risperidone has an alert to a potential falls risk. New or changes in medications or interventions are monitored for effectiveness. The GP verified the care provided by staff at Alexandra Rest Home was of a high standard. Residents

		and family/whānau members expressed a high level of satisfaction with the care provided. There are enough supplies of equipment seen to be available to meet the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The activities programme at Alexandra Rest Home is provided by an activities co-ordinator with the support of two volunteers. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activity programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Local school children and children from a nearby creche participate in activities at Alexandra on a regular basis. Daily van outings enable residents to shop locally. The location enables some residents to walk to the local shops. An initiative was implemented to address a request by residents to access the internet, and this is an area identified as one of continuous improvement. The local library offers training in computer skills and residents are assisted to use this service if they wish. Family/whānau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. A residents' meeting is held six monthly. Meeting minutes, and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated daily and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A resident who had been started on a medication, is recorded to not have responded as desired. The medication is stopped and a new one commenced. Evaluations of the improvement is sighted. Evidence of comprehensive evaluation is sighted in eight of eight files reviewed. A short-term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified

		residents and family/whānau are included and informed of all changes.
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	Residents are supported to access or seek referral to other health and/or disability service providers' i.e. respiratory outpatient department, hospice, psycho-geriatric team and district nurses. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from Capital Coast District Health Board (CCDHB). Referrals are followed up on a regular basis by the RN or the GP. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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	Staff follow documented processes for the management of waste, infectious and hazardous substances. Policies were reviewed 26 October 2017. Appropriate signage is displayed where necessary. An external company is contracted to supply rubbish bins and to manage waste. Waste is recycled into rubbish, recycling and compost. Waste is collected three times a week. The laundry and cleaning products are stored in the basement in a locked room. Material safety data sheets and product information was readily available where chemicals were stored and utilised. Staff interviewed knew what to do if a chemical spill or event occurred. A spill kit was available and accessible if needed. Continence products are also kept in this storage area. Adequate supplies and resources were sighted. Personal protective equipment is stored but is readily available around the facility. Staff were observed using this. Yellow waste and sharps are collected by a separate company as needed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness was sighted framed on the wall in the entrance to the facility. The expiry date was documented as the 25 June 2019. All legislative requirements are met. The maintenance manual was reviewed. Appropriate systems are in place to ensure the physical environment of the rest home is fit for purpose and is maintained. The testing and tagging of all electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the manager and observation of the environment. All efforts are made to ensure the environment is safe, appropriate for the elderly and/or disabled and the care setting. The environment is hazard free and residents' safety is paramount. Independence is promoted at every opportunity. Residents interviewed confirmed they know the processes to follow if any repairs or maintenance is required. The book is checked on a daily basis and records are kept in a separate folder as each request

		is actioned. The manager is responsible for the maintenance programme and explained there is a list of preferred providers for general repairs and emergency call outs as needed.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the rest home. There are two ensuite bathrooms. There are toilets and showers in each wing in close proximity to the resident's individual rooms. There is a designated toilet for visitor use which has keypad access. There is also a separate toilet for staff to access.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided to allow residents to move around freely within their bedrooms safely. The rooms are all single accommodation. Rooms are personalised with photographs, soft furnishings, toys, paintings and other personal effects to promote a homely atmosphere. There is adequate room to store mobility aides and wheel chairs. Staff, residents and family/whānau reported the adequacy of the bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are two lounges in the facility one is very spacious and is available for residents to engage in the activities provided. There is a small separate lounge which was being used for residents interested in computer activities such as skyping with family/whānau or watching a movie of their choice. Paintings are displayed in all service areas in the rest home. Comfortable seating is in both lounges suitable for the client group. The dining room is spacious with easy access for residents and staff. Residents can access areas for privacy if required. The communal areas meet the needs of the residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to	FA	Staff cover the laundry seven days a week. Laundry is delivered to the laundry by way of a laundry chute. Linen is sorted by staff in the basement laundry set up to ensure personal clothing is laundered on site. There are two washing machines and one drier with racks to hang woollens to air dry naturally. There is one staff member in attendance for all laundry shifts and one staff member completes the daily cleaning for this facility. The cleaner's trolley was stored safely in a locked room when not in use. The

the setting in which the service is being provided.		linen is contracted out to be laundered in the community by a designated contractor. Laundry is delivered to and from this service provider in the rest home vehicle driven by the activity's coordinator as part of the role. Infection prevention and control measures are in place and this was explained by the staff. All laundry products used are stored in the basement and are labelled appropriately. Residents/families interviewed reported the laundry is managed effectively and personal clothes are returned in a timely manner. Both cleaning and laundry processes are monitored by the manager using the organisation's internal audit programme on a regular basis.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and Civil Defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service 07 February 2006. Fire drills are held six monthly (last drill held 06 August 2018) and a record of staff who attended is recorded. The staff orientation/induction includes fire and security training. Staff interviewed confirmed their knowledge and understanding of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, torches, batteries, a gas barbecue and gas hob other resources are available and stored downstairs. A diesel generator, emergency power and lighting are available, and all are checked regularly. A nurse call system is installed for residents if requiring assistance. Staff were observed to respond promptly to the call bells activated. Security arrangements are in place. Doors and windows are locked at a predetermined time. The facility is checked by staff on the afternoon and nightshifts on a regular basis. The stairway to the basement is locked securely and has key pad only access.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and	FA	All communal rooms and individual residents' rooms are appropriately heated and ventilated. Rooms were observed to all have natural light and external windows that opened to the outside. The rest home is elevated so there was minimal opening onto external areas. Electrical heating is provided. The rooms are thermostat controlled in each individual resident's room sighted. The temperature is maintained between 20 to 23 degrees Celsius. Three monthly monitoring of heating occurs. The manager ensures that all forms of lighting are used that reduce glare and that residents are able to control where

comfortable temperature.		necessary. Families and residents confirmed that the facility is maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The infection control (IC) programme, reviewed annually, establishes, maintains and monitors procedures covering IC practices. The IC practices are guided by the IC manual, with assistance from the CCDHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the IC manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined. The facilities commitment to increasing the number of staff accessing the flu injection and reducing the risk of flu symptoms to residents is an area recognised as one of continuous improvement.
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 care manager is the infection control officer (ICO) and is responsible for implementing the infection control programme, with input from the IC committee. The ICO reports directly to the general manager. A position description is included in the IC programme. The ICO and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted, and interview verified the ICO attends quarterly ongoing IC training at the CCDHB and receives regular email updates.
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	FA	The IC programme includes policies and procedures which are current and signed off by ICO and the IC committee. Staff interviewed verified knowledge of IC policies. Staff were observed to be compliant with generalised IC practices. Any residents with potential infections are placed in isolation promptly. A resident with ESBL is managed as per guidelines.

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verify staff have received education in IC and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation. Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family/whānau interviews.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. These are collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality and staff meetings every month and any necessary corrective actions discussed, as evidenced by meeting records, IC records and staff interviews. Any immediate action required is presented to staff at hand over. Incidents of infections are graphed and on display in the staff room. A comparison of previous infection rates is used to analyse the effectiveness of the programme and evidences a marked reduction in infections/antibiotic use. A past listeriosis infection was diagnosed and transferred to the CCDHB. A resident diagnosed with campylobacter was isolated promptly and managed appropriately with guidance from Public Health and the DHB. There have been no outbreaks of norovirus at Alexandra Rest Home within the past five years
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Alexandra Rest Home does not use restraints. The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134.2008). It states that the service refrains from the use of restraints. The service had no restraints or enablers in use at the time of audit as evidenced by observation, documentation and interview. The restraint register verifies no restraints have been used since 2005. The services policy was understood by all clinical staff interviewed and annual education related to restraint is a mandatory attendance topic. The restraint co-ordinator is the care manager, and the restraint committee meets every six months as evidenced by meeting minutes.

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.

No data to display

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	CI	All unplanned or untoward events including shortfalls in order to identify opportunities to improve service delivery and to identify and manage risk are clearly documented. A system is developed and implemented. Incident/adverse events records were reviewed. Staff reported all near miss as well as actual events and when interviewed clearly understood the reasons for reporting the details accurately. The care manager ensures all incident forms are reviewed and signed off. Any essential notifications to external agencies would be completed if required. Follow-up is completed by the care manager in partnership with the managers and the quality assurance/health and safety officer. Significant reductions in falls has occurred with low incidences reported and evidenced on the electronic system which summarises and produces graphs of incidents, times of day incidents occurred, severity of risks and identification of any hazards. The quality manager collated all incidents and accidents and provides the quality assurance team with detailed reports. Family were kept well informed and this was evidenced on the forms reviewed. Feedback was given to staff and information displayed on the noticeboard in the staff	Having fully attained the criterion the service clearly demonstrates a review and analysis process of incidents and accidents to ensure appropriate corrective action planning has been undertaken to improve the safety and care delivery of residents. One example relates to a resident who had a fall resulting in a fracture (appropriate notification was made). Follow up included involvement of care staff, staffing level at the time, the time of the day and other factors. The resident details of discharge from public hospital were documented and an action plan was developed prior to discharge to the facility. The residents’ dietary requirements were reviewed by a

		room.	dietitian to ensure a high protein diet was put in place to assist the healing process. The physiotherapist developed a rehabilitation plan which was implemented by staff.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Increased admission of residents with literacy in internet technology (IT) and an increase in admission of residents under 65 years identified the need for expansion of the traditional activity programme, that previously had met all resident's needs. Five residents or their families had made specific remarks regarding this area of need not being provided. In response to this request, in February 2017, internet access was provided for residents in one specific area of the facility with a Wi-Fi access point. Residents however had to use the administrator's computer for skype calls, and residents could only access Wi-Fi on their phones or tablets in this region. One resident would use a laptop in the lounge. In February 2018 at the request of the GP, a resident with limited mobility and a terminal illness was assisted to maintain and enhance quality of life by being provided with Wi-Fi access in the privacy of the bedroom. This has enabled the resident to have contact with their friends and family/whānau around the world. In March 2018 Wi-Fi access was extended to a large part of the facility and unlimited access to the internet provided free. A resident's computer is set up in a secluded corner of the facility, to enable residents without their own devices to access the internet. A resident was observed using the computer consistently during the audit. The residents have Wi-Fi access on any device at no charge at any time. Residents play online games with people overseas. Skype calls to family/whānau or friends can be made in the privacy of the resident's room Residents can access movies and videos as desired. Several staff have skills that enable the ability to assist residents with IT support if needed. The local library provides training to anyone to learn computer skills, daily. Alexandra Rest Home supports residents to access this. A review of the initiative is sighted, that evidences increased satisfaction by the younger residents residing at Alexandra, with the activities programme	Having fully attained the criterion the service clearly demonstrates a review and analysis of the activities programme to ensure appropriate corrective action has been undertaken to provide the residents with access to the internet. The service responded to the requests of five younger residents to provide an activities programme that included access to social networks. Free access to the internet and Wi-Fi throughout the facility has been provided. A review and analysis of the initiative was undertaken and verifies residents satisfaction with the initiative as evidenced by resident satisfaction surveys, observations and resident interviews.

Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.	CI	In 2016 the percentage of staff having the flu injection was 61%. An initiative was started by the CCDHB in 2017 to challenge all aged care providers in the Wellington Region to promote the uptake of the flu injection to staff in aged care facilities, to ultimately reduce the incidence of exposure to the flu to residents. Alexandra Rest Home implemented an initiative to increase the uptake of the flu vaccination to staff and increased the percentage of staff vaccinated to 81%. The achievement of gaining the 'best result', in comparison to other aged care facilities in the Wellington Region was recognised by the CCDHB. In 2018 a further effort was made to improve the number of staff involved. It was noted, if the staff weren't on duty when the GP visited to vaccinate, there was a reluctance to visit the GP in their own time and receive the vaccination. The GM managed a process whereby if a staff member on duty desired the vaccination, and hadn't received it, they would take the staff member to the pharmacy and the pharmacist would administer the vaccination. In 2018 the uptake of the flu injection in staff at Alexandra Rest Home is 85.7%. Those that haven't received it are on extended leave over the winter for varying reasons. Residents satisfaction has increased as a result of residents having a reduction in the incidence of flu, respiratory infections and a reduction in admissions to the DHB as a result of flu like symptoms over the June-August 2018.	The residents at Alexandra Rest home, have had their exposure to the flu in 2018 minimised, by the organisation implementing an initiative to assist staff members to receive the vaccination. The resources provided by Alexandra Rest Home have improved staffs access to enable them to receive the flu injection. This has increased the number of staff receiving the vaccination, reduced the number of staff exposing residents to flu like symptoms, and reduced the incidence of flu in residents.

End of the report.