

Tranquillity Bay Care Limited - Tranquillity Bay care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Tranquillity Bay Care Limited

Premises audited: Tranquillity Bay Care

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 12 March 2019 End date: 13 March 2019

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: 33

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

Tranquillity Bay Care provides rest home level care for up to 34 residents. This certification audit was conducted against the relevant health and disability standards and the provider's contract with the district health board. There have been no changes to the organisation, or the facility, since the last audit.

The audit included a review of policies and procedures, interviews with staff, residents, family members and the general practitioner. Resident and staff files were sampled.

The organisation has achieved full compliance with all requirements.

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 organisation operates in a way that complies with consumer rights legislation. Residents' privacy, independence and personal safety is protected. Care and support is provided in a manner which recognises the residents' culture, values and beliefs.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles.

Communication is open and resident choices are recorded and acted upon. The informed consent process has been maintained. Links with family/whanau and the community are encouraged and supported by the service provider.

The complaints process meets the requirements of consumer rights legislation.

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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The directors monitor organisational performance. Management are suitably qualified. Quality activities are implemented and quality goals are defined and monitored. Data is used to improved services if required. The required policies and procedures are documented. The adverse event reporting system ensures that all events are reported and managed appropriately. A range of quality improvements have recently been developed and are now being implemented. There is an implemented risk management system.

Human resource processes meet all requirements. Staff are orientated and trained. There are a sufficient number of suitably qualified staff on duty at all times.

Resident records are well maintained and meet all the requirements of this standard.

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.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service and a baseline assessment is conducted upon admission. The clinical manager and registered nurses are responsible for care plan development with input from the residents, staff and family member representatives. Residents, family/whanau and staff interviewed confirmed that the care plans were consistent with meeting residents identified needs.

Planned activities are appropriate to the residents' assessed needs and abilities. Residents expressed satisfaction with the activities programme in place.

Medicines are managed and administered in line with current legislations and regulations. All medications are reviewed by the general practitioner (GP) according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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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The facility is well maintained and meets the needs of the residents. The required building and emergency requirements have been maintained. Emergency equipment is available and emergency procedures are documented.

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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At the time of the audit there were no residents requiring a restraint or enabler. There are documented procedures in the event a restraint or enabler are required. All staff have received training regarding the minimisation of restraints and the management of behaviours of concern.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Interviewed staff demonstrated knowledge of the Code of Health and Disability Services Consumers` Rights (the Code). The Code is included in staff orientation and in the staff training education programmes. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents. The residents and family/whanau reported that staff respect their rights and incorporate them as part of their everyday practice.</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>Policies and procedures on consent support the residents` right to make informed decisions. The CM reported that informed consent is discussed and recorded at the time the resident is admitted to the facility. The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives. The residents' files sampled had the required consent forms signed by the resident, or where appropriate, signed by the enduring power of attorney (EPOA). The files contained copies of any advance care planning and the residents' wishes for end of life care. Staff acknowledged the residents' right to make choices based on information presented to them. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy / support is provided annually.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints process complies with consumer rights legislation. All residents are provided with information regarding the complaints process, and advocacy services, on entry. Information regarding the complaints process is displayed.</p> <p>Records of resident complaints were sampled. There have been three documented complaints since the last audit. Records sampled confirmed that the complaints were taken seriously and resolved to the satisfaction of the complainant. The complaints were fully investigated, documented and corrective action developed as required. The complaints register has been maintained. Complaints are fully discussed at quality meetings. This was confirmed in meeting minutes sampled. The managing director confirmed that there have been no complaints made to external authorities.</p> <p>Residents and family interviewed confirmed they have had the complaints procedure explained to them and they know how to make a complaint if required. Staff are aware of their responsibility to record and report any resident or family complaint they may receive.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code and information about the Code, advocacy services and the complaints process are provided to the residents on admission and displayed at the facility. The clinical manager (CM) reported that advocacy services can be accessed as required.</p> <p>Residents and family/whanau interviewed were aware of their rights and confirmed that information was provided to them during the admission process. The information pack was sighted and outlines the services offered. Signed residents' agreements were sighted and meet the requirements of this standard and district health board requirements.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The organisation respects the physical, visual, auditory, and personal privacy of residents and their belongings at all times. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting resident's individual beliefs and values. The majority of rooms are single occupancy, with one couple currently sharing a double room. Personal property is maintained in a secure manner. Policies and procedures on abuse and neglect include definitions and reporting requirements.</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 a Maori health plan and individual values and beliefs policy which include cultural safety and awareness. Terminal care and death of the Maori resident is included. Cultural needs are included in the care plans (if identified). There were residents who identified as Maori and stated that their cultural needs were met. There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. The organisation maintains contact with local Iwi. Cultural safety training is provided to all staff. The Code is available in Maori and satisfaction surveys include cultural and spiritual beliefs.</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>Cultural needs are determined on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident. Values and beliefs are discussed and incorporated into the care plan. Residents and family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plan. At the time of the audit, there was one resident who had a cultural care plan. This was well documented.</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>Policies define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct and professional behaviour is included in the employment and orientation process. Staff receive information and education regarding non-discriminatory attitudes and behaviours.</p> <p>Interviews with residents and family, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. In interview, the general practitioner (GP) confirmed the provision of consistent and respectful care to all residents.</p> <p>Management representatives stated that there have been no reported alleged episodes of</p>

		abuse, neglect or discrimination towards residents.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are systems in place to ensure staff receive a wide range of opportunities which promote good practice within the facility. Staff reported that they were satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice. There are regular visits by the GP and allied health providers as required. The CM and RN are available and accessible to care staff for clinical support and advice when required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy and procedure in place. Staff interviewed evidenced their knowledge around open disclosure. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documenting of open disclosure following incidents/accidents was evident. Family/whanau reported they are informed of any events or concerns. Records of family contact are maintained.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The organisation is owned and operated by Tranquillity Bay Care Limited. There are two directors, one of which is the managing director and the other is the general manager. Both directors have been working in aged care industry for many years and maintain current knowledge of the industry. Day to day management is the responsibility of the managing director who is on site Monday to Friday. The directors are supported by a clinical manager who has over six years' experience in aged care.</p> <p>The strategic direction for the organisation is documented. The annual business plan for 2019 identifies key goals for the organisation. The mission statement has recently been reviewed. Organisational performance is monitored. A relatively new governance reporting process has been established which enables the directors to monitor achievement towards key organisational goals.</p> <p>On the day of audit, there were 33 residents. Two residents were funded under a mental health contract and 10 residents were paying privately. There were three residents under the age of 65 years.</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>	<p>FA</p>	<p>In the event of a temporary absence of the directors, management duties are divided between the office manager and the clinical manager. Both have the required relevant experience to perform the role of management over a short period of time, and have previously done so effectively.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented quality and risk management system. The required policies and procedures are documented. A full review of policies and procedures was conducted by the lead auditor prior to the onsite audit. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation and guidelines and evidenced-based practice. Policies are available to staff in hard copy. All policies are subject to regular reviews. Clinical policies and procedures are reviewed by the clinical manager. There is a document control process. Obsolete documents are removed from circulation.</p> <p>A range of quality related activities are implemented. Services are monitored through complaints and resident feedback, satisfaction surveys, review of adverse events, surveillance of infections, health and safety reports and implementation of an internal audit programme. Corrective action plans are documented when required, with evidence of closure. A quality indicator data form summarizes quality data monthly including identification of any trends. Records of meeting minutes sampled confirmed that quality data is discussed and communicated throughout the organisation.</p> <p>A new quality improvement process has been developed since the last audit. A number of quality improvement projects have been implemented. Records of recently developed improvements confirmed early evidence of continuous improvements in systems and clinical practice.</p> <p>An organisational risk management programme is in place. The risk management programme covers the scope of the organisation with risk levels and mitigation strategies documented. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety inspections are included in the internal audit programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>FA</p>	<p>The process for managing adverse events is documented and communicated to staff. Records of adverse events sampled confirmed appropriate immediate actions, full investigation and timely closure. Adverse event reports had a corresponding note in the progress notes to inform</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>staff and demonstrated that family were notified where required. The managing director is aware of situations in which the organisation would need to report and notify statutory authorities.</p> <p>Adverse events are categorised and collated with any trends identified. Discussions regarding the results of investigations are documented in the quality/health and safety team meeting minutes. Records sampled confirmed discussions regarding prevention of reoccurrence and near misses.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff files sampled confirmed the validation of qualifications. This included copies of annual practicing certificates for the registered nurses, evidence of first aid certificates, food safety training and certificates of health and wellbeing training for health care assistants. Records of orientation, employment contracts, position descriptions, reference checks, police vetting and performance appraisals were also sighted in staff files sampled.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts until they demonstrate competency. The orientation programme covers the essential components of service delivery.</p> <p>Ongoing staff training is conducted against the annual training plan. Training is delivered by the clinical manager and a range of external providers. All training resources provided include a quiz from which the clinical manager can assess understanding. Mandatory competencies are defined. This includes medication management and handwashing. Evidence of the completed competencies are kept on staff files. The registered nurses have access to clinical training provided by the district health board. The clinical manager and registered nurse have both completed interRAI training. An individual record of staff attendance at training is maintained.</p> <p>Improvements have been made to the performance review process including a system to ensure reviews are up to date and completed annually. The administrator also maintains a staff data base which is utilised to monitor that all staff requirements have been maintained.</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</p>	<p>FA</p>	<p>There is a documented staffing rational. The rational is developed in line with district health board contract requirements. The managing director reports that staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in resident acuity and occupancy.</p> <p>There is a registered nurse on site for 13 days over a fortnight. When not onsite, the registered nurses share on call duty. There are three health care assistants rostered on the morning shift;</p>

<p>service providers.</p>		<p>three in the afternoon and two overnight. There are designated staff for activities, maintenance and cleaning/laundry. The activities staff are also on site 13 days over a fortnight. The availability of a registered nurse and activity staff member for 13 days over the fortnight ensures ongoing support for the weekend staff.</p> <p>Rosters are prepared four weeks in advance. Rosters sampled confirmed a sufficient number of staff over the 24-hour period, seven days per week. There is evidence that staff members are replaced in the event of an unplanned absence. Residents and family members interviewed confirmed that they have timely access to staff when required.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Accurate residents' records are maintained. Resident records are maintained in hard copy and securely stored in the nurse's station. A record of past residents is also maintained. Resident records are integrated with entries from allied health providers included in the resident folder. Entries are made in resident progress notes daily, with additional entries made if an event occurs. Additional records also include daily checklists which are used by the health care assistants for documenting daily interventions.</p> <p>All records sampled included the name and designation of the writer with the name of the resident on each page. Records were legible. A specimen signature list is included in each resident file. Archived records are stored on site in a dry and secure location. There is a system for tracking archived records should they need to be retrieved.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The welcome pack contains all the information about entry to the service. All enquiries are recorded on the pre-enquiry form. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed all entry requirements were conducted within the required time frames. Family/Whanau and residents interviewed confirmed that they received adequate information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the district health board is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in</p>

transfer from services.		the residents' records to confirm this.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system is implemented to ensure that residents receive medicines in a safe, secure and timely manner. Medication charts sampled complied with legislation, protocols and guidelines. Medications are stored in a safe and secure way in the treatment rooms and locked cupboards. Medication reconciliation is conducted by the CM and RN when the resident is transferred back to service. The service uses a pre-packed medication management system. All medicines are reviewed every three months and as required by the GP. Allergies are clearly indicated and resident photos are current for easy identification.</p> <p>An annual medication competency is completed for all staff administering medication and medication training records were sighted. The RN was observed administering medicines correctly. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medications are stored appropriately. As when necessary medicines are documented and administered after consultations with on call clinical team. Outcomes are documented detailing either effectiveness or non-effectiveness of administered medication.</p> <p>The residents who were residents self-administering medication at the time of the audit had been assessed as competent. Medicines were kept in a secure way in locked cupboards and records were maintained.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines appropriate to the resident group. Meal services are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. Residents' weight is monitored regularly, and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no</p>

		expired items were sighted. The food service was registered under the new food control plan.
<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>	FA	The clinical manager reported that all consumers who are declined entry are recorded on the pre-enquiry form. When a consumer is declined entry, family/whanau are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	All residents are admitted with a completed needs assessment and coordination services form. The initial assessments are completed within the required time frame on admission while care plans and interRAI assessments are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. Care plans are resident focussed, integrated and provide continuity of service delivery. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
<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>	FA	The documented interventions in short term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Monthly observations are completed and are up to date. Adequate clinical supplies are observed, and the staff confirmed they have access to the supplies and products they needed.

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Planned activities are meaningful to the residents. Activities are conducted by the diversional therapist and activities coordinator. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents and caters for all residents including those under 65 years of age. The activities staff reported that they modify activities based on the resident's response and interests and also according to the capability and cognitive abilities of the residents.</p> <p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The management of waste and hazardous substances is documented in policy and meets legislation and local authority requirements. Domestic waste is placed in a skip and removed twice per week. Continence products are bagged appropriately. Hazardous substances are identified on the hazard register and stored appropriately. Chemicals are stored securely. The oxygen cylinder is secure. Sharps containers are on the medication trolley and in the nurse's station. Observations confirmed that there are adequate supplies of personal protective equipment placed throughout the facility. Staff orientation and ongoing training includes the</p>

		management of waste and hazardous substances.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility is semi-rural, large and divided into three main areas. The Seaview wing and Manaia wing are connected by an enclosed corridor. The Manaia wing is two story with stairs and a lift. Residents living in the Manaia wing have been assessed as having a greater degree of independence. There are large grounds and gardens for the residents to access. Outside areas are safe and accessible. There is a current building warrant of fitness and a planned maintenance schedule. Records of planned, and ongoing maintenance requirements are maintained.</p> <p>Records of compliance and calibration have been maintained. Medical equipment is calibrated as required. There is a test and tag programme in place for electrical equipment. Hazards are identified and monitored through the health and safety programme. Building and environmental audits are included in the routine internal audit programme.</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 a combination of communal, shared and private ensuites. Communal bathrooms are identified. Toilet facilities are located throughout the facility and are in close proximity to residents' rooms and communal areas. All resident rooms have a hand basin. Visitor facilities are available and identifiable. Hot water temperatures are monitored to ensure that hot water is provided at a consistently safe temperature.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is currently one double room which is shared by a couple. The rest of the bedrooms are single occupancy. There is sufficient space in all bedrooms to accommodate personal possessions and equipment.</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</p>	FA	<p>Both Seaview wing and Manaia wing have adequate communal areas to accommodate residents, activities and dining. The Seaview wing has a separate dining room adjoining the lounge. The Manaia wing has the lounge and dining room combined. There are also additional lounging areas throughout the facility where residents can remove themselves from the main</p>

areas to meet their relaxation, activity, and dining needs.		lounge area if they wish to do so.
<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 documented processes for the management of cleaning and laundry services. All laundry is laundered on site. The laundry has sufficient equipment and clearly identifies clean and dirty areas. The cleaner's trolley is stored in the laundry. Material data safety sheets are displayed. There is a closed-circuit chemical dispensing system. Additional chemicals are securely stored. Staff involved in laundry and cleaning processes have received the required training.</p> <p>Cleaning and laundry processes are monitored through the resident satisfaction process and internal audits. Internal audits and resident meeting minutes sample confirmed general satisfaction with all cleaning and laundry activities.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an approved fire evacuation plan which has recently been reviewed by a fire consultant to determine that the required safety requirements are in place. Trial evacuation drills are conducted every six months. Staff attendance at trial evacuation drills is monitored. The facility is separated into fire cells for a staged evacuation. The required fire emergency equipment is located throughout the building. All staff receive training in emergency and evacuation procedures.</p> <p>There are sufficient emergency supplies. Civil defence and pandemic equipment is stored and readily accessible. There is back up water and food supplies. There are current first aid kits. Alternative energy sources include gas cooking facilities and emergency lighting. All staff have a current first aid certificate.</p> <p>The facility is secure. Security checks are completed each evening. There is a CCTV camera at the front door and entrance to the facility. There are security lights located on the outside of the building.</p> <p>The call bell system has been maintained. Staff carry a pager which identifies the location of activated call bells. Random checks on the call bell system are routinely conducted.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate</p>	FA	<p>The facility has adequate heating and ventilation. Communal areas in both wings have a wood burner and oil heaters in each of the resident's rooms. Fans are strategically located around the facility during the warmer weather. All rooms have windows which enable plenty of natural</p>

natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		light. There is a designated place, away from the buildings, for residents who smoke.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The organisation provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical manager is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</p>	FA	<p>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The organisation provides relevant education on infection control to all service providers, support staff, and residents. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There is a job description for the position of the restraint coordinator this is the clinical manager. The service has no restraints and no enablers in use on audit day. Restraint and challenging behaviour training is provided.</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.

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, 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.