Golden Concept E Limited - Eversleigh Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Golden Concept E Limited
Premises audited:	Eversleigh Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 February 2019 End date: 1 March 2019

Proposed changes to current services (if any): The service has been verified as suitable to provide hospital-medical level care under their current hospital certification

Total beds occupied across all premises included in the audit on the first day of the audit: 29

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

Eversleigh Hospital provides rest home and hospital level care for up to 38 residents. At the time of the audit there were 29 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at Eversleigh Hospital.

The service is managed by a facility manager who has been at Eversleigh Hospital since January 2018 and has worked in the aged care sector in clinical and facility management roles for over 20 years. She is supported by a senior registered nurse and an administrator.

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

This certification identified one area for improvement around the complaints procedure.

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.		Some standards applicable to this service partially attained and of low risk.

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. The complaints policy describes the management of the complaints process. Residents and family interviewed, verified ongoing involvement with community.

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.

There is a quality and risk management programme in place. Progress with the quality and risk management programme is designed to monitor contractual and standards compliance and to ensure that residents receive care in the best possible way. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Appropriate employment processes are adhered to and all employees have an annual staff performance appraisal completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is a documented annual in-service education schedule. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and health care assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP. The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the 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.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have hand basins and there are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. A civil

defence/emergency plan is documented for the service. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. On the day of audit there were three residents using restraints and one resident with an enabler. Three resident files where restraint was being used were reviewed and included completed restraint assessment and consent forms. Staff receive training in restraint minimisation and challenging behaviour management.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is

used to determine infection control activities and education needs within the facility. A quality project has seen a reduction in the number of fungal infections. There have been no outbreaks.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with eight care staff, including four healthcare assistants (HCA), two registered nurses (RN), one cook and one activities coordinator confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Six residents (one rest home and five hospital) and three relatives (all hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (one rest home and five hospital). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney forms were filed in residents' charts.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, going shopping, and attending cafés and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints policy describes the management of the complaints process. There are complaint forms available at the entrance of the facility. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register in place, however not all complaints were entered on the register. Twelve complaints (eleven in 2018 and one in 2019 year to date) have been made since the last audit, however not all complaints reviewed had documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that includes the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Bi-monthly resident/relative meetings provide the opportunity to raise concerns. An annual resident/relative satisfaction survey is completed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education on

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		abuse and neglect was provided in July 2018.
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	Eversleigh Hospital has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were no residents who identified as Māori. Māori consultation is available through the local Kaumātua. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. Staff interviewed could describe how they are incorporated into daily care
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities and staff sign a copy on employment. The staff meeting occurs monthly and includes discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, RNs and HCAs confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The facility manager is responsible for coordinating the internal audit programme. Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the facility manager and the RNs. Care staff complete competencies relevant to their practice.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. Fourteen incidents/accident forms were reviewed for January and February 2019. The forms included a section to record family notification. The incident/accident forms indicated family were informed or if family did not wish to be informed. Family members interviewed confirmed they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Eversleigh is owned and operated by Golden Concepts E Limited who purchased the service in May 2015. The service provides rest home and hospital level care for up to 38 residents, which includes three beds in the serviced apartments. At the time of the audit there were 29 residents in total; one rest home level and 25 hospital level, there were no rest home residents in the serviced apartments. All beds are dual purpose beds as verified at the last audit. All residents were under the age related residential care (ARRC) agreement. This audit also included verifying the service as suitable to provide hospital-medical level care under their current hospital certification. The service has a business plan, which is reviewed regularly. The service has quality goals for 2019 and the goals for 2018 have been reviewed. The service is managed by a facility manager who has been at Eversleigh Hospital since January 2018 and has worked in the aged care sector in clinical and facility management roles for over 20 years. She is supported by a senior registered nurse and an administrator. The facility manager has completed at least eight hours of professional development.
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	During a temporary absence, the senior RN covers the facility manager's role with the support from the care staff.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Golden Concepts E Limited has an overall business/strategic plan and Eversleigh has a facility quality and risk management programme in place. The plan is robust and appropriate for the change to all dual service beds (hospital and rest home). There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support both rest home and hospital level care. Facility meetings held include; monthly quality/risk, RN, staff and kitchen meetings, and a bi-monthly resident/relative meeting. An annual resident and relative satisfaction survey was completed in November 2018 with an overall satisfaction rate of 91.1%. Corrective actions were implemented around food services, staffing and environment, evidencing that any suggestions and concerns were addressed. Meetings minutes sighted continue to evidence there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results. There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off. There is an implemented health and safety and risk management system in place including policies to guide practice. The facility manager is responsible for health and safety education, internal audits and accident/incident investigation. There is a current hazard register in place and was last reviewed in June 2018. Staff confirmed they are kept informed around health and safety matters at meetings. Falls management strategies include assessments after falls and individualised strategies.
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.	FA	There is an accidents and incidents reporting policy. The facility manager investigates accidents and near misses and analysis of incident trends occurs. Fourteen resident related incident reports were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observation forms were documented and completed for six unwitnessed falls with a potential head injury. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed since the last audit.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resource management policies in place. A copy of practising certificates is kept. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. Six staff files were reviewed (one facility manager, one RN, two HCAs, one administrator and one activities coordinator) and evidence that reference checks were completed before employment is offered and all had relevant documentation relating to employment. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and believed new staff were adequately orientated to the service. The facility manager and RNs are able to attend external training, including sessions provided by the local DHB. Two of the four RNs have completed interRAI training with the other two booked in for training in March 2019. There is an annual education planner in place that covers compulsory education requirements over a two-year period. Staff interviewed stated that training takes place and they are given training to care for residents' conditions.
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 policy in place that determines staffing levels and skill mixes for safe service delivery. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The roster is flexible to adapt to changes in resident need and/or numbers including ensuring residents in the serviced apartments are supported. The facility manager (RN) and the senior RN are on duty during the day from Monday to Friday. An RN is available on call weekends and after hours and can contact the facility manager as required for any clinical concerns. There is a RN on duty 24 hours. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the facility manager and senior RN who respond quickly to after-hours calls. The service is divided into two wings. In wing A, there are 13 of 17 residents (one rest home and 12 hospital). There is an RN and two HCAs (one long and one short shift) on the morning shift, two HCAs (two long and one short shift) in the afternoon shift and one HCA on the night shift. In wing B which includes the three serviced apartments, there are 16 of 21 residents (all hospital). There were no residents in the serviced apartments at the time of the audit. There is an RN and two HCAs (one long and one short shift) on the morning shift, two HCAs (two long and one short shift) in the afternoon shift and one HCA on the night shift. The RN on the afternoon shift and RN on the night shift cover both wings.
Standard 1.2.9: Consumer Information Management	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office.

Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.
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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. Five admission agreements sighted were signed and dated. One is still with a daughter waiting to be signed. The facility manager has followed this up.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on site. The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are administered by the RN or senior medication competent HCAs. Medication education has been completed in the last year. The medication fridge temperature is checked weekly. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food,	FA	The service has one cook who works Monday to Friday and one cook who works weekends. There is a kitchenhand on each morning shift and a kitchen assistant who works from 4.00 pm to7.00 pm. All have current food safety certificates. The head cook oversees the procurement of the food and management

fluids and nutritional needs are met where this service is a component of service delivery.		of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in the dining rooms from bain maries. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. On the second day of audit the residents enjoyed a barbeque in the garden. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked regularly, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals. The food control plan was approved on 29 May 2018.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all six residents whose files were sampled. Other assessments tools in use were falls risk, pressure injury risk, pain and continence. Care plans sampled were developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with

continuity of service delivery.		documented input from a range of specialist care professionals including the podiatrist, wound care specialist (one chronic wound) and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow, and guidelines were clear.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and this was confirmed by family members interviewed. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being treated. One chronic wound has had input from the GP and wound care specialist. There is one stage one and one stage two pressure injury. Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is an activities coordinator who oversees the activities programme. She works 25 hours a week Monday to Friday. She is about to commence a diversional therapy course. There are often volunteers who come in at weekends and the activities coordinator leaves out puzzles and colouring-in books. On the day of audit residents were observed doing exercises, going for assisted walks outside and listening to music. Pet therapy and a barbeque also occurred. There is a weekly programme in large print on noticeboards in the lounges and hallways. The activities coordinator visits each room as soon as on duty to say hello and to tell them what's happening that day. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, gardening and walks outside. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is a monthly interdenominational church service held in the facility. Catholic lay volunteers give communion to Catholics weekly. There are fortnightly van outings. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day, the Melbourne Cup and Valentine's Day are celebrated. A pet therapy team visits monthly and one resident has a dog who visits everyone. There is community input from schools, Age Concern, volunteers, a kapa haka group, a Tongan dance group and a ukulele group. Residents have an activity assessment completed over the

		first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held three monthly. The one rest home resident interviewed stated, 'I like to join in all activities and I'm never lonely here'.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The six long-term care plans reviewed had been evaluated by the RN six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the RN identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
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	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.
Standard 1.4.2: Facility	FA	The building holds a current warrant of fitness which expires 1 June 2019. There is a

Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		maintenance/gardener person on site for 20 hours a week. Contractors are used when required. Electrical equipment has been tested and tagged. Hoists are checked six monthly and the scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen and laundry have vinyl flooring. Residents' rooms are carpeted, and communal showers and toilets have non-slip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.
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	All rooms have hand basins. There are sufficient communal showers and toilets. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chair/hoists if required. There are privacy signs on all shower/toilet doors.
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 are 34 single rooms and one double. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are two dining rooms

their relaxation, activity, and dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is done on site by cleaners on a rostered system. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The laundry is closed when not in use. The cleaner’s equipment was attended at all times or locked away. All cleaning chemicals were labelled. There are two sluice rooms. Disposal of waste water occurs here.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has an emergency/disaster management plan in place. There is a staff member with a current first aid certificate on duty 24/7. There is an approved NZ Fire Service evacuation scheme in place, letter dated 14 December 2007. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 13 December 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored (bottled water and water tank) for emergency use for three litres per resident for three days. Alternative heating and cooking facilities (BBQ and gas hobs in the kitchen) are available. Emergency lighting is available for up to four hours. There is a call bell system in place and there are call bells in the residents’ rooms, lounge and dining room areas. Residents were observed to have their call bells in close proximity. Visitors and contractors sign in at reception when visiting.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. All heating is electric. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents smoke. All other areas are smoke free.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to	FA	There is an infection control coordinator (a RN) who is responsible for infection control across the facility. The coordinator has only been in the role for two months. Currently there is no infection control (IC) committee but the coordinator is keen to set one up. Responsibility for infection control is described in the job description. The IC coordinator oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the facility manager. Visitors are asked not to visit if unwell. Hand

consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.
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	Although the IC coordinator has only been in the role for two months she is a very experienced RN. She has access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies include a range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the facility manager with input from Golden Concept E Ltd
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have completed hand hygiene audits and have participated in IC education. This year staff have already attended an in-service on fungal infections (in response to a rise in fungal infections) and there are two more IC education sessions planned for 2019. Resident education occurs as part of providing daily cares and as applicable at resident meetings.

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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. There was recently a rise in fungal infections and the IC coordinator responded by reporting this at a staff meeting and having an in-service session on prevention of fungal infections. The incidence has declined. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit the service had three residents using restraints (two bed rails and one lap belt) and one resident using an enabler (bed rail). The care plans for three resident files with restraints reviewed, were up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to an RN. Staff receive training in the safe use of restraint (April 2018).
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Three resident files where restraint was being used were reviewed. The files included a restraint assessment and consent form that was signed by the resident's family. The completed assessment considered those listed in 2.2.2.1 (a) - (h).

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Restraint use is reviewed monthly during the quality improvement meetings. The review process includes discussing whether continued use of restraint is indicated.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least three-monthly as part of restraint evaluations. Restraint usage throughout the organisation is also monitored regularly and reported monthly. The service has actively worked on minimising the use of restraint and on the day of audit the two restraints in use were at the request of family.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	The complaints policy describes the management of the complaints process. There is a complaint register in place, however not all complaints were entered on the register. Twelve complaints (eleven in 2018 and one in 2019 year to date) have been made since the last audit, however not all complaints reviewed had documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome.	There is a complaint register in place, however four complaints had not been entered on the register. Twelve complaints (eleven in 2018 and one in 2019 year to date) have been made since the last audit, however six of the twelve complaints reviewed did not have documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome.	Ensure that all complaints are entered on the complaint register and that the complaint outcomes are communicated to the complainant and that the complainants are happy with the outcome. 90 days

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.

No data to display

End of the report.