

MA Healthcare Group Limited - Awanui Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: MA HealthCare Group Limited

Premises audited: Awanui Rest Home

Services audited: Dementia care

Dates of audit: Start date: 3 May 2019 End date: 3 May 2019

Proposed changes to current services (if any): Nil

Total beds occupied across all premises included in the audit on the first day of the audit: 23

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
Yellow	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
Red	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

Awanui Rest Home is privately owned and operated and provides dementia level of care for up to 24 residents. On the day of the audit there were 23 residents.

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

The facility manager is on site during the week with a registered nurse providing clinical oversight. The residents and relatives spoke positively about the care and supports provided at Awanui Rest Home.

Improvements identified at the audit are required to the following: training, including completion of performance appraisals, first aid certificates, medication competencies, staff trained in dementia, and to emergency drills; consent forms and enduring power of attorney documented; medication administration.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the service with pamphlets given to residents and family on entry. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints and advocacy. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service's mission, vision and philosophy are clearly identified and recorded in the organisation's documents and published information. Awanui has an implemented quality and risk management system. Key components of the quality management

system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards.

Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are staff on duty at all times to meet needs of residents in the dementia unit. There is an implemented orientation programme that provides new staff with relevant information for safe work practice.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is an admission package available prior to or on entry to the service. A registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with 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 practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist 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 outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Families commented positively on the meals. Snacks are always available.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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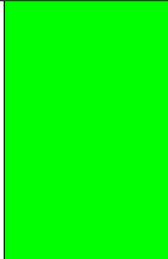
Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are 24 rooms with hand basins. All rooms share communal showers/toilets. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available. There is a large fenced off garden. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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Restraint minimisation processes are in place. Staff demonstrated knowledge on the restraint use minimisation and safe practice policy and alternative methods that may be used. All staff have received education on challenging behaviour management. The service is a secure facility.

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 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. 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	41	0	0	4	0	0
Criteria	0	88	0	1	4	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>Posters and pamphlets describing the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are displayed in the service and are available to family members. Staff files reviewed confirmed the Code is included in staff orientation and through ongoing education. Staff interviewed confirmed knowledge of the Code. Policies and procedure outline the Code and rights and describe how it is incorporated into everyday practice. Interactions observed between staff and residents demonstrated implementation of the requirements of the Code.</p> <p>Staff interviewed (two healthcare assistants who work across all shifts, the registered nurse, facility manager, cook, diversional therapist, maintenance, laundry and cleaning staff) could describe how they incorporate resident choice into their activities of daily living.</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>	PA Moderate	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on five out of eight resident 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 (EPOA) evidence is filed in the residents' charts. One resident's file had no activated EPOA.</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 policy and procedure document references resident's rights to access, and the contact details of advocacy services, cultural services, and spiritual advocates. The policy and procedure document, the admission agreement, and the client information brochure also lists the contact details for the Nationwide Health and Disability Advocacy Service. The policy and procedure document advises of the residents' right to independent advice and support.</p> <p>Family members interviewed confirmed they had received information regarding access to advocacy services via the information brochure and the pre-admission pack. Family are encouraged to involve themselves as advocates. Advocacy brochures are available in the office.</p> <p>Staff interviewed confirmed their understanding of residents' rights to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family are encouraged to visit as confirmed by family interviewed. Family members were also seen to engage with residents during the day of audit. Residents are supported and encouraged to partake in the planned activities programme as per their care plan. This was confirmed in residents' records sampled.</p> <p>Discussions with family identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident's family and chosen social networks.</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>A policy and procedure is attached to every admission agreement and is in line with Right 10 of the Code. The procedure provides details regarding how to make a complaint, who to make a complaint to, and includes contact details, timeframes for responding, and how to access advocacy services.</p> <p>A complaints register is maintained. All complaints are managed by the registered nurse with oversight by the facility manager. A review of the quality process confirmed that the complaints process is integrated with the quality programme.</p> <p>There has been one complaint forwarded to the service by the district health board. This was filed prior to the previous management team being in place and is being responded to by the facility manager and registered nurse. There have not been any other complaints from other external providers since the last audit.</p>

		Staff interviewed confirmed their knowledge of the complaints process. Family interviewed confirmed they understand their right to complain.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information for new residents, family, and friends, in relation to the Code, is in the pre-admission pack, admission agreement, and information brochure. This information includes accessing advocacy services. Five family members interviewed confirmed their understanding of the Code and stated that information had been provided around the Code on entry to the service. They all stated that their members rights are respected when receiving resident related services and care.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Processes implemented by management and staff ensure the residents right to privacy and dignity are recognised and respected at all times. Residents adorn their rooms with personal belongings. There was one double room with single occupancy. Services are provided in a manner that maximises each resident's independence. Information from the activity's assessment guide, guides care planning around activities the resident previously enjoyed. Policy defines abuse and neglect, references legislation, and provides instruction on dealing with suspected or alleged abuse and neglect. Staff receive education regarding abuse and neglect. Staff interviewed verbalised the actions of everyday practice to ensure residents are treated with respect and privacy whilst encouraging independence. All family interviewed, stated that they were very satisfied with the service provided. Staff, the general practitioner and family all stated that there was no evidence of abuse or neglect. Values, beliefs, and cultural needs are met by the service. This was evidenced by care planning sighted. There is one church minister who comes in weekly for specific residents and some residents have family who take them to services in the community.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a	FA	The service is committed to ensuring that the individual's customs and beliefs, as well as the cultural and ethnic backgrounds of Māori, are valued and fostered within the service. Staff value and encourage the participation of family/whānau in daily care of the residents. Cultural values and beliefs are documented in the residents' care plans, which are personalised for the

<p>manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>two Māori residents. One family member who identified as Māori stated that their family needs and values were well looked after and considered. They also stated that family were included in discussions.</p> <p>Staff receive education on cultural awareness in their orientation and are aware of the importance of whānau in the delivery of care for Māori residents. There is access to interpreter services and residents' information is available in Māori.</p> <p>The facility manager identifies as Māori and has links into the community should Māori advisors be required.</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>	<p>FA</p>	<p>The activities assessment documents information pertaining to the resident's values, beliefs, and cultural requirements prior to dementia. This information is used for planning care and diversional activities. All families interviewed confirmed they were involved in the development of the residents' care plan and in the activity's assessment. Staff interviewed confirmed Awanui Rest Home's philosophy of assisting all residents to maintain their independence.</p> <p>There are residents in the service who identify as Pasifika. All speak and understand English and do not require interpreting services. A family member interviewed who identified as Pasifika stated that their family member was well supported. Staff are also employed who can speak languages of the residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There is a code of conduct and house rules that define professional boundaries. These are discussed with new staff and signed by any new employee during their orientation process. Interviews with staff confirmed their understanding of professional boundaries. Staff demonstrated care and compassion towards the residents, and families interviewed stated that this was a highlight for them, of the service provided to their family member. Families interviewed did not express any concerns related to staff breaching any professional boundaries. Previous and current training plans sampled confirmed there is ongoing education regarding discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	<p>FA</p>	<p>Policies and procedures which guide staff actions are linked to evidence-based practice and are referenced accordingly. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these are updated at</p>

<p>appropriate standard.</p>		<p>regular intervals by an external consultant. The facility manager and registered nurse have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by the registered nurse and facility manager interviewed.</p> <p>Staffing is provided to meet resident needs. There is also a general practitioner who visits the facility at least fortnightly and as required. The general practitioner stated that they were confident in the skills and abilities of the newly appointed facility manager and registered nurse.</p> <p>Family members interviewed confirmed they are very happy and satisfied with the care provided to their relatives.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff were observed communicating effectively with residents and their families. Open disclosure policies outline the way in which information is to be provided to the residents and families. The information brochure provides a comprehensive range of information regarding the services provided. The admission pack gives comprehensive information regarding the scope of the service including services requiring additional fees.</p> <p>Family are involved in an annual resident's review. There is evidence that informal communication with family members occurs regularly. Families are kept informed of any incidents, accidents, or change in the resident's health care status. This was confirmed through a sample of clinical files.</p> <p>Access to interpreting services is available but have not been required. Family members were observed to speak in their own language to their family member on the day of audit. Family members interviewed confirmed they were kept well informed and were encouraged to visit the unit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Awanui Rest Home is privately owned. The director also owns one other rest home and relies on the facility manager and registered nurse to inform them of any issues that may arise in this service.</p> <p>The service provides dementia level of care for a total of 24 beds under the aged residential care agreement (ARC). There were 23 residents on the day of the audit. None were under the age of 65 years. The manager informed that no other level of care is provided. All but one room is for single occupancy and the double room is currently occupied by one resident only.</p>

		<p>The service has a current business plan which identifies the objectives and goals of the service. A mission statement, philosophy, and objectives are in place and reflect a resident centred approach. The core value 'living well with dementia' is stated on the entrance sign.</p> <p>The facility manager has had extensive experience (over 30 years) in managing aged care services including owning an aged care service in the past. The manager has responsibility for operational matters. Additional professional advice is sought from an external contractor if required. The manager is supported by a registered nurse (RN) who works five days a week. The manager and registered nurse attend over eight hours of professional education a year. The manager's roles and responsibilities are clearly defined in the position description.</p> <p>Interviews with family confirmed that the service meets the high level of care needed for their family members.</p> <p>Management and staff reported sufficient staffing, resourcing, and equipment to provide care.</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>Appropriate procedures are in place to ensure operation of the service continues in the absence of the facility manager. The facility manager role is undertaken by the registered nurse and director, should there be a temporary absence of the facility manager. The registered nurse at the sister facility (owned by the same director) can provide support in an acting role if the registered nurse is on leave. The facility manager also stated that a bureau registered nurse would be contracted if there was a further requirement for registered nurse hours on site.</p> <p>Staff interviewed confirmed service provision is undertaken in a timely, appropriate, and safe manner.</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>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that have been developed by an external consultant. These have been reviewed regularly.</p> <p>The quality programme includes an annual internal audit schedule that has been implemented. Audit summaries and corrective action plans are documented where a noncompliance is identified. Issues and outcomes are reported and discussed at the monthly staff meeting. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a timely manner.</p> <p>The monthly staff meeting includes discussion around all aspects of the quality programme</p>

		<p>including incidents, accidents, complaints, health and safety, infection control, clinical issues, staffing, survey results and discussion of improvements. The meeting serves as a forum to review progress towards goals documented in the quality plan. Discussions with the registered nurse, the facility manager and staff confirmed their involvement in the quality programme.</p> <p>There is an annual satisfaction survey with five returns for April 2019 already submitted. Results to date indicate a high level of satisfaction with the service. Any opportunities for improvement are identified as being a one-off comment.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents, and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. All hazard forms reviewed showed evidence of resolution of issues in a timely manner.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse, unplanned or untoward events via the accident/incident forms. The fifteen incident and accident forms reviewed confirmed that these are signed off by the facility manager and/or registered nurse with information collated and reported on a monthly basis. There is an open disclosure policy.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse event reporting. Family members interviewed confirmed that information provided to them regarding adverse events was in line with the principles of open disclosure. The facility manager understands the statutory and regulatory obligations in relation to essential notifications to the correct authority. Three notifications have been made to the Ministry of Health (MoH) since the last audit. One was in relation to a resident leaving the property unattended (police involved), one in relation to a complaint, and one in relation to behavioural issues from one resident to another.</p> <p>Samples of incident/accident forms confirmed that data is analysed, and corrective actions implemented. Trends are identified and fed back at staff meetings and handover.</p>
<p>Standard 1.2.7: Human Resource Management</p>	PA Moderate	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>outline accountability, responsibilities and authority. These were reviewed on staff files along with: employment agreements; reference checking; and completed orientations.</p> <p>Copies of current annual practising certificates were sighted for all staff that require them to practice. The facility manager and registered nurse are responsible for the in-service education programme. All staff have received training in challenging behaviour and dementia care and have either completed or are completing the Careerforce education modules. Annual education plans were viewed. All the 2018 education was delivered, and the 2019 education plan being implemented as per schedule (link 1.3.12.3).</p> <p>Staff files provided evidenced that all staff complete an orientation programme, and all are expected to have completed an annual appraisal. The registered nurse has completed interRAI training. The registered nurse at the sister facility has also completed interRAI training. Kitchen staff have completed safe food handling training.</p> <p>Six of the fourteen healthcare assistants who work in the dementia unit have completed appropriate training in dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels are based on the needs of the residents. Staffing levels meet contractual requirements. The facility manager and registered nurse together are responsible for rostering. Rosters reviewed for April 2019 confirmed that staff are replaced if on leave. Staff confirmed there are adequate staff on each shift to meet the needs of the residents and family interviewed stated that there are always staff available to support residents when they come in.</p> <p>Healthcare assistants rostered include AM: three long shift and one short shift; PM: two long and one short shift; and two HCAs overnight.</p> <p>The facility manager, registered nurse and diversional therapist work Monday to Friday. There are dedicated kitchen, laundry, cleaning, maintenance, and garden staff.</p> <p>A registered nurse is on duty five days a week with 40 hours a week allocated. The registered nurse lives on a neighbouring property and provides on call support. Details of staff rationale and skill mix are documented in policy.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	<p>FA</p>	<p>The resident's name, date of birth, and the National Health Index (NHI) number are used as unique identifier on all residents' information sighted. Clinical notes sampled were current and accessible to all staff and in an integrated file. On the day of the admission all relevant</p>

<p>identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>information is entered into the resident's file by the registered nurse following an initial assessment, and by the doctor when they visit. The files are kept secure in the staff office. No personal or private information was observed to be on display on the days of the audit.</p> <p>Archived records are safely stored on site in a locked store shed for 10 years. These are catalogued and easily retrieved. Obsolete records are destroyed through document destruction services.</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>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 met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All but one admission agreement sighted were signed and dated. The family of the resident with the unsigned admission agreement lives out of town but has promised to post back. The facility has followed up on this.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>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. The facility uses the 'yellow envelope' transfer system. Communication with family is made. A resident was transferred to Auckland DHB on the day of audit and all guidelines/policies were observed.</p>
<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>	<p>PA Moderate</p>	<p>There are comprehensive 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. All policies and procedures had been adhered to. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The RN and senior medication competent HCAs administer medications. Staff do not have up to date medication competencies. There had been medication education in 2018 and more is planned for this year. The medication fridge temperature is checked daily. Eye drops are not dated once opened.</p> <p>Staff sign for the administration of medications electronically. Ten medication charts were</p>

		<p>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 prescribed.</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>The service has a head cook who works Monday – Friday 0700-1530. There are two other cooks who cover weekends and annual leave. There are no kitchenhands. All cooks have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site.</p> <p>Meals are served in the dining room directly from the kitchen servery. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. Meals were observed to be hot and well-presented and some residents were able to say that they were enjoying their meal.</p> <p>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, and these were all within safe limits. HCAs serve the evening meal and food temperatures are checked at this time as well.</p> <p>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 family members interviewed were satisfied with the meals. Snacks are available at all times.</p> <p>The food control plan is currently being documented. Inspection is due shortly on a planned and confirmed date.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential 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 to the referring agency.</p>

appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>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 long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) nutrition, behaviour and continence.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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. Relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the district nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>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. Family are notified.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently two simple wounds being treated. There are currently no pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a DT who works six hours a day Monday to Friday except for Thursday which is seven hours. On the days of audit residents were observed going for walks, going for a van ride, joining in a quiz and playing bingo.</p> <p>There is a weekly programme in large print on whiteboards in each wing and some less cognitively impaired residents have a copy in their room. The programme can vary from the printed programme due to residents' mood and fatigue. 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, music, van outings and walks outside.</p> <p>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.</p> <p>Residents who wish to attend church go out with their families/friends, but a Catholic nun comes in to give communion weekly.</p> <p>There are van outings twice weekly. If it is fine weather, the residents go for walks every day. The DT also takes small groups shopping.</p> <p>Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated.</p> <p>There is a chicken run in the garden and residents enjoy going with staff to collect the eggs. Family members bring in their dogs to visit. The DT is currently negotiating to have a pet therapy team visit.</p> <p>As the residents enjoy music and singing the new manager and DT are planning to have entertainers come in.</p> <p>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 monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>Five care plans reviewed had been evaluated by the registered nurse 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</p>

manner.		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. Family members interviewed confirmed that they are informed of any changes to the care plan.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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 mental health services for older people and the district nurse for wound advice. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</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>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 29 November 2019. There is a maintenance person/gardener who works sixteen hours a week. Contractors are available when required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges are carpeted but hallways and bedrooms have vinyl. 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 are well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. There is a large fenced-off garden where residents can roam at will. There is a raised vegetable garden and a chicken run. The separate administration building has the façade of a general store.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care for dementia level of care residents.</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	All rooms have hand-basins. All rooms share communal showers and toilets and there are sufficient of these. 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 chairs. There are signs on all shower/toilet doors.
<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	There are 23 single rooms and one double. The double is only ever used for single occupancy. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The lounges/dining areas are ample. There are small areas where residents who prefer quieter activities or visitors may sit. Activities occur in the larger areas.
<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	All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All chemicals on the cleaner’s trolley were labelled. There is a sluice in the laundry for the disposal of soiled water or waste and the sluicing of soiled linen if required. The laundry is kept closed when not in use.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	PA Moderate	There is an approved evacuation scheme in place dated 16 December 1998, which remains applicable as there has been no modifications to the building.

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>There is a comprehensive emergency management plan in place. The civil defence kits are kept in a locked shed outside. Review of these confirmed all equipment within its expiry date. The emergency water tank in the garden holds 800 litres. The emergency food supply is sufficient for three days for full occupancy and staffing. There is an emergency gas BBQ provided for cooking. Alternative light source is through large torches.</p> <p>The facility is secured at all times. Staff receive security training and are aware of when to call emergency services. Evidence of training was sampled on staff files. Emergency education for staff includes six monthly trial evacuations. The latest fire drill/evacuation was conducted in February 2018, however these have not been completed six monthly as required. Fire equipment is checked monthly by an approved provider. Sprinkler and smoke alarms are in each room and are monitored through a central system.</p> <p>The call bell system has been replaced by sensor mats. Original call bells remain in bathrooms and toilets for staff to summon additional help if needed. Staff interviewed confirmed sensor mats work effectively.</p> <p>There is a requirement for at least one staff trained in first aid to be on site.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents who wish to smoke are supervised. All other areas are smoke free.</p>
<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>	<p>FA</p>	<p>There is an infection control coordinator (a RN) who is responsible for infection control across the facility. The coordinator liaises with and reports to the facility manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the facility manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There have been no outbreaks.</p>
<p>Standard 3.2: Implementing the infection</p>	<p>FA</p>	<p>Even though they have only been in the role for four months the IC coordinator is a very experienced registered nurse who has had previous IC experience at a district health board.</p>

<p>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>		<p>They have access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</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 provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive 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 were developed by an external infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>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 participated in IC education in the last year and there is training planned for 2019. Resident education is difficult due to residents' cognitive impairment; however, staff are role models for newer staff in ways of managing challenging behaviour.</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>	<p>FA</p>	<p>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 with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint coordinator is the RN. Processes for minimising restraint use and safe practice are in place. Types of authorised restraint are bedrails and lap belts, but these are not used for any resident in the service. The facility manager and registered nurse are focused on maintaining a restraint-free service noting that the service is a secure facility with</p>

		<p>environmental restraint in the form of high fencing hidden by gardens. There is a locked coded gate, where family go in and out as they please. Annual restraint minimisation training for all staff was completed and records of training were sighted. Restraint competencies for all staff were current.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Moderate	Signed informed consents and advanced directives were evident on four out of five files sampled. The sample was extended to three more files. Two out of three of these files did not have a signed consent. EPOAs were activated on four out of five files however one file had no EPOA.	<p>(i) Three out of eight residents do not have a signed consent form.</p> <p>(ii). One resident admitted in October 2018 has no EPOA.</p>	<p>(i). Ensure all residents have a consent form.</p> <p>(ii). Ensure all residents have an EPOA.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	The training policy states that each staff member will have an annual performance appraisal. Two of the initial five staff files reviewed should have had an annual performance appraisal; however, both records showed that these were outdated. The sample size was increased and a further two staff records reviewed showed that annual appraisals were out of date.	(i). Four of seven staff records reviewed had an outdated performance appraisal last completed over a	(i). Ensure that staff have an annual performance appraisal completed.

		Six of the fourteen healthcare assistants who work in the dementia unit have completed appropriate training in dementia standards. Five other healthcare assistants have worked in the dementia service for over six months and they are not currently enrolled or have not completed dementia training as per contractual specifications. Three other healthcare assistants have not been in the role for six months yet. Staff interviewed described senior staff role modelling good practice and practice as per policy.	year ago. (ii). Five of the fourteen healthcare assistants who work in the service have not completed dementia training as per contractual specifications and are not enrolled in training.	(ii). Ensure that all staff who have been employed in the service for longer than six months are enrolled in or have completed dementia training against set standards. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	There are comprehensive policies and procedures in place for all aspects of medication management. The facility uses an electronic and robotic pack system. There is only one eye drop currently being administered and this has not been dated when opened. When questioned the three HCAs interviewed were unaware that this should occur.	Eye drops are not dated when opened.	Date all eye drops when opened. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	The registered nurse and one senior HCA are medication competent. The RNs competency is checked by an external RN.	Eleven senior HCAs administering medications do not have medication competencies.	Ensure all HCAs administering medications have completed medication competencies. 30 days

<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Moderate</p>	<p>Staff are required to complete first aid training with rosters documented to ensure that there is at least one staff member with a first aid certificate on duty at all times. The registered nurse and one other senior healthcare assistant has a current first aid certificate. The facility manager stated that six others have completed first aid training however documentation (certificates) has not yet been issued. The registered nurse lives on site and stated that they would be able to respond in an emergency in the meantime if required for first aid.</p> <p>Emergency drills are expected to be completed six monthly. The last drill was completed for staff in February 2019, the previous before that was February 2018 (a year).</p>	<p>(i). There are only two staff who have completed first aid training and a review of rosters confirmed that there is not a first aider on duty at all times.</p> <p>(ii). Emergency drills are not held at least six monthly.</p>	<p>(i). Ensure that there is at least one staff member with a first aid certificate on duty at all times.</p> <p>(ii). Ensure that emergency drills are held for staff at least six monthly.</p> <p>90 days</p>
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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.