

# ERH Care Limited - The Greenwood Home

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## 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:

<b>Legal entity:</b>	ERH Care Limited	
<b>Premises audited:</b>	The Greenwood Home	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 10 February 2020	End date: 10 February 2020
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	16	

# Executive summary of the audit

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## 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

The Greenwood Rest Home provides rest home level care for up to 26 residents. On the day of audit, there were two residents at rest home level of care, and 14 private boarders.

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' files, observations, and an interview with one resident, management, staff and a general practitioner.

The owner/manager was unavailable. The clinical coordinator/registered nurse is appropriately qualified and experienced. There are established quality systems and processes. Feedback from one resident and the general practitioner was very positive about the care and services provided.

This certification audit identified that improvements are required in relation to professional development; document control; staff files; timeliness of interRAI assessments and long-term care plan evaluations; care interventions; and first aid/CPR training for staff.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Greenwood Rest Home provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The business plan describes the facility's goals and objectives. Policies and procedures are established. Quality data is collected and collated. A system for the documentation of adverse, unplanned and untoward events is established. There is an implemented health and safety programme. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that is designed to provide new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</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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There is an admission package available prior to, or on entry to the service. The clinical coordinator is responsible for service provision. The resident's plans are developed with the resident and/or family/whānau input. Resident files included medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

Medication policies are implemented. The registered nurse and healthcare assistants (HCAs) responsible for the administration of medicines complete medication competencies. Medication charts are reviewed three-monthly by the general practitioner.

The activity programme is coordinated and implemented by the clinical coordinator and HCA on morning duty. The activity programme includes tai chi, exercises, entertainers, outings and celebrations.

All meals are cooked on site. The menu has been reviewed by a dietitian. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

## 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.		Some standards applicable to this service partially attained and of low risk.
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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. Six residents' rooms have toilet ensuites and there are sufficient communal showers/toilets for the others. Access to external areas are safe and provide shade and seating. Cleaning and laundry services are monitored through the internal auditing system.

Appropriate training, information and equipment for responding to civil and pandemic emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of approved restraints and enablers. The clinical coordinator is the restraint coordinator. Staff receive regular education and training on restraint minimisation. At the time of the audit there were no residents who required either a restraint or an enabler.

## 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. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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)
<b>Standards</b>	0	39	0	4	2	0	0
<b>Criteria</b>	0	87	0	4	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) is being implemented at this rest home level aged care facility. Staff interviewed (one clinical coordinator/registered nurse (RN), one healthcare assistant (HCA), one cleaner/laundry, one cook) could provide examples of how the Code is incorporated into their job role and responsibilities. Staff receive training about the Code during their induction to the service. This training continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established policies and procedures around informed consent and advanced directives (link 1.2.3.4). There are signed general consents for release of information, outings and photographs in two of two rest home files reviewed. The general practitioner assesses the resident's competency to make a resuscitation status. Resuscitation and advance directives were appropriately signed. Discussions with the clinical coordinator and one HCA confirmed that they were familiar with the requirements to obtain informed consent before entering rooms and for personal cares. Both resident files had a copy of their enduring power of attorney.</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>Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. The resident interviewed was aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</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>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.</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>There is a complaints policy to guide practice that aligns with Right 10 of the Code (link 1.2.3.4). A complaints register is maintained. Concerns/complaints are discussed during the staff meeting as sighted in the meeting minutes (link 1.2.3.6). Complaints forms are visible within the facility. There have been no complaints lodged since the previous audit (6 March 2019). The resident interviewed was aware of the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families during their entry to the service. The clinical coordinator discusses aspects of the Code with residents and their family on admission. One resident interviewed reported that their rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The residents' personal belongings are used to decorate their rooms. The care staff interviewed (one clinical coordinator, one HCA) reported that they knock on bedroom doors prior to entering rooms and promote the residents' independence by encouraging them to be as active as possible. The resident interviewed and observations during the audit confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins during their induction to the service.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. There are policies and guidelines to assist staff in the delivery of culturally safe care for Māori (link 1.2.3.4). The service has access to cultural advisors through the DHB. There was one resident who identified as Māori. She confirmed during an interview that her values and beliefs are upheld by the service. She enjoys speaking te reo Māori with others. Her file was reviewed. A Māori assessment was completed that lists the resident's iwi and links their values and beliefs to the four cornerstones of health. Special instructions are documented in relation to tangihanga (death).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in consultation with the resident, whānau/family and/or their representative. Beliefs and values were incorporated into the residents' care plans in resident files reviewed. Residents interviewed confirmed they were involved in developing the resident plan of care, which includes the identification of individual values and beliefs. One resident identifies as Indian and speaks Hindi with staff. Indian food is offered and a friend also brings in food for this resident. He was unable to be interviewed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the HCAs role and responsibilities. Professional boundaries are reconfirmed through education and training sessions and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Examples of good practice were evident during the audit. The clinical coordinator is on site a minimum of 40 hours per week and is on call when not available on site. She is supported by a second RN that is available in her absence. The resident interviewed reported that they are very satisfied with the services received. A resident/family satisfaction survey was completed in September 2019. There is a policy to guide staff on the process around open disclosure (link 1.2.3.4). Residents interviewed confirmed the admission process and agreement was discussed with them and they</p>

		<p>were provided with adequate information on entry. Discussions and notifications with relatives are recorded on the communication page in the resident file. Five incident forms reviewed (2018) identified family were notified following a resident incident. The clinical coordinator interviewed confirmed family are kept informed (eg, incident/accident, doctor visit, change in resident's state of health). Two responses were returned (one resident, one relative) and were very positive. Interviews with staff confirmed that the teamwork amongst staff is very good.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure (link 1.2.3.4). Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Discussions and notifications with relatives are recorded on the communication page in the resident file. Five incident forms reviewed (2018) identified family were notified following a resident incident. The clinical coordinator interviewed confirmed family are kept informed (eg, incident/accident, doctor visit, change in resident's state of health).</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>	PA Low	<p>Greenwood Lodge provides care for up to 26 rest home level residents and 16 residents were living at the facility at the time of the audit. There were two rest home level residents at the time of the audit. Both residents were under the aged residential care services contract (ARCC). An additional 14 boarders were living at the facility with funding arrangements through Work and Income New Zealand (WINZ). These boarders do not receive cares.</p> <p>The facility manager/owner was the director of this facility for three years prior to purchasing it in 2019. He was unavailable during the audit due to being in quarantine (potential exposure to Coronavirus). A 2019 business plan has been implemented that includes a mission, philosophy, and nursing objectives. This business plan is regularly reviewed by the owner and clinical coordinator.</p> <p>The clinical coordinator has attended a minimum of eight hours of professional development over the past year relating to her respective role and responsibilities. This was unable to be confirmed for the facility manager.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in</p>	FA	<p>The clinical coordinator is responsible for business operations during the absence of the owner/manager. An RN from another Auckland based rest home with the same ownership is responsible for clinical operations in the absence of the clinical coordinator.</p>

<p>an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management plan and quality and risk policies describe quality improvement processes. These documents are overdue for review.</p> <p>Quality management systems include internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data that is collected is evaluated. Corrective actions are documented and implemented where improvements are identified. Information was shared in staff meetings until September 2019.</p> <p>The health and safety manual was last updated in November 2019. The owner/manager is the health and safety officer. Health and safety is discussed at orientation (link 1.2.7.3) and staff meetings. Staff report hazards and a hazard register is maintained (reviewed 8 November 2019). Actual and potential risks are documented on the current hazard register.</p> <p>Falls management strategies and the development of specific falls management plans are in place to meet the needs of individual residents who are at risk of falling. Strategies implemented to reduce the number of falls for residents at risk include regular toileting, intentional rounding and sensor mats.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	<p>FA</p>	<p>There is an accident/incident reporting policy that includes definitions and outlines responsibilities (link 1.2.3.4). Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme.</p> <p>No accidents or incidents have been reported in 2019 or 2020 (year to date). Five incident/accident forms were reviewed for 2018 (three falls, one bruise and one skin tear) and all were completed in full with evidence of appropriate follow-up action(s) taken.</p> <p>The clinical coordinator reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. No section 31 notification forms have been required since the previous audit.</p>
<p><b>Standard 1.2.7: Human Resource</b></p>	<p>PA Low</p>	<p>Human resources policies are in place to support recruitment practices. Staff files are held in a locked area and were not able to be accessed due to the owner/manager not being available. A</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>copy of an employment agreement and the new staff orientation package were sighted. The service has an orientation programme in place that provides new staff with relevant information for safe work practice (confirmed during interviews with the staff). Staff interviewed believed new staff were adequately orientated to the service on employment. Current practising certificates were sighted for the clinical coordinator, general practitioner, and pharmacy.</p> <p>An education and training programme covering the relevant requirements is implemented and attendance records are maintained. There is an in-service topic each month. Staff also attend the ADHB training day on offer (three staff attended on 13 Feb 2019). The clinical coordinator completes competencies relevant to her role including medication competencies. She has not attended interRAI training yet (link 1.3.3.3). Since the draft report a new RN has been employed that is interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>At the time of the audit, there were 16 residents. Only two residents living in the care facility were rest home level and the remaining 14 residents were boarders who do not receive cares. RN cover is provided by the clinical coordinator 40 hours per week which includes two-night shifts. The clinical coordinator is on call when not available on site. RN hours are documented on the staff roster.</p> <p>One HCA is responsible for the two rest home level residents 24 hours a day, seven days a week. Shifts vary from 8-hour shifts to 12-hour shifts. There are separate cleaning/laundry staff rostered seven days a week (0800 – 1300). The owner/manager is responsible for maintenance. The HCA and one resident interviewed informed there are sufficient staff on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Archived records are kept secure. Residents' files demonstrated service integration. Entries were legible, dated, timed and signed by the relevant HCA or RN, including designation.</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 meet the requirements of the ARCC contract. Exclusions from the service are included in the admission agreement. Both rest home residents had signed admission agreements.</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.</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>FA</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. The clinical coordinator and medication competent HCAs had completed medication competencies. The service uses an electronic medication system. Regular medications are received in robotic rolls and checked against the electronic medication chart which identified the pack had been checked in. 'As required' medications in blister packs are checked weekly for stock levels and expiry. There are no standing orders. There were no self-medicating residents. There were no eye drops in use. There were no restricted medications on site. Medications are stored in a separate container in the kitchen fridge which is monitored daily for temperatures and these were within the acceptable range for the storage of medications.</p> <p>Two of two rest home medication charts were reviewed on the electronic system. Photo ID and allergy status are recorded. Medication charts are reviewed at least three-monthly by the GP.</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>	<p>FA</p>	<p>The service employs a cook from 0800 to 1600 seven days a week. There is a four-week seasonal menu in place which has been reviewed by a dietitian (May 2019). The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Dietary requests are accommodated. Cultural requirements are met such as Indian food. A vegetarian diet is provided for one resident. Foods are delivered on the meal trolley to the dining room where the meals are served. There are gas and electric cooking appliances. All foods were date labelled.</p> <p>The food control plan expires June 2020. The cook has completed food safety and hygiene training. Kitchen fridge and freezer temperatures are monitored and recorded daily. End cooked</p>

		<p>food temperatures are taken and recorded at all meals. The dishwasher is checked for effectiveness by the chemical provider. There are completed cleaning schedules. There are insect screens on the windows.</p> <p>The resident interviewed was happy with the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	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 back to the referring agency.</p>
<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 reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files contained appropriate assessment tools and first interRAI assessments for the two long-term residents; however, six-monthly routine assessments have not been completed (link 1.3.3.3). Care plans reviewed have been developed on the basis of assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans are individually developed with the resident, and family involvement is evidenced by the signature on the care plan. The clinical coordinator is responsible for all aspects of care planning. One of two care plans did not include specific interventions for identified medical and clinical needs. Assessments and care plans include input from allied health including the GP, medical specialist and podiatry.</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 clinical coordinator initiates a GP consultation. Care staff stated that they notify family members about any changes in their relative's health status. Discussions and notifications with relatives are recorded on the communication page in the resident file. There are short-term care plans in place for short-term needs which are reviewed by the clinical coordinator and are either resolved or added to the long-term care plan as an ongoing problem.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including</p>

		<p>continence and wound care supplies and these were sighted. There were no wounds on the day of audit. The clinical coordinator advised wound care is undertaken by the HCA who reports to the clinical coordinator if there are any issues identified. The facility has access to wound care specialist advice if required.</p> <p>Monitoring forms are in use as applicable such as weight, blood pressure, vital signs and bowel monitoring. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p><b>Standard 1.3.7: Planned Activities</b> Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is a weekly programme of morning and afternoon activities for the two rest home residents and all independent residents (boarders). Activities are coordinated and delivered by the senior HCA on duty and the clinical coordinator Monday to Saturday. Some activities are resident led such as piano playing by an independent resident. Exercises are scheduled daily and there is Tai Chi weekly, taken by members of the Chinese community group. Other activities include newspaper reading, games, quizzes, sing-a-longs, videos and supervised walks. There are weekly church services and the denominations rotate. An entertainer visits monthly and brings in his dog for pet therapy. The library service visits and a hairdresser visits fortnightly. The facility has a separate TV lounge and larger lounge for entertainment and other gatherings.</p> <p>The service shares a van with a "sister" facility for weekly bus outings to places of interest. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated.</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. Activity plans are in place for the two rest home residents however these have not been evaluated at least six monthly (link 1.3.3.3). The resident interviewed was happy with the activities and outings offered.</p>
<p><b>Standard 1.3.8: Evaluation</b> Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The two long-term care plans reviewed had been developed by the clinical coordinator, however these had not been evaluated six-monthly (link 1.3.3.3) 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. Activity plans are in place for each resident and these had not been evaluated six-monthly. The multidisciplinary review involves the clinical coordinator, GP and resident/family if they wish to attend.</p>
<p><b>Standard 1.3.9: Referral To Other Health</b></p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The</p>

<p>And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the clinical coordinator and GP confirmed that the service has access to a wide range of support either through the specialists or 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. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. There is sluice tub in the laundry if required. Gloves, aprons and goggles are available for staff. The cleaner/laundry staff member was observed to be wearing appropriate personal protective clothing when carrying out their duties.</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 that expires 30 September 2020. The owner oversees the maintenance programme. There is a maintenance request book in place (sighted) with requests for repairs which had been signed off when completed. There is a planned maintenance schedule in place. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated including the blood pressure machine and chair scales. Hot water temperatures have been monitored in resident areas and are within the acceptable range.</p> <p>Residents were observed moving freely around the areas with mobility aids where required. The corridors are wide and there are handrails in place. There is safe access to the external areas with outdoor seating and shade. There is safe access to all communal areas.</p> <p>The clinical coordinator and HCA interviewed stated they have sufficient equipment to carry out resident cares.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities.</p>	FA	<p>All rooms are single occupancy. All bedrooms but four have hand basins. There are six resident rooms with a toilet ensuite. There are adequate numbers of communal toilets and showers for residents. There is appropriate signage and the fixtures and handrails appropriately placed. There are privacy signs on all shower/toilet doors.</p>

Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<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	All rooms are single and spacious enough for residents to mobilise around with walking aids. Residents are encouraged to personalise their rooms as desired.
<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	There are large and small communal areas. Activities/entertainment occurs in the larger lounge and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. One TV lounge has seating arranged to allow small group or individual activities. Some lounges open out onto attractive courtyard areas. There is a separate dining room. There is safe access to the external 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 and cleaning are undertaken by a designated person from 0800 to 1300, seven days a week. The laundry is located downstairs. There is a defined clean/dirty area that could be described by the cleaner/laundry person interviewed. The commercial laundry equipment is serviced regularly by staff. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or safely stored in a locked room when not in use. There is a chemical dispenser for the chemicals used.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Emergency, disaster policies and procedures are documented for the service. The orientation programme and annual education/training programme include fire, emergency management and security training. Staff interviewed confirmed their understanding of emergency procedures. There is an approved fire evacuation plan. Fire drills occur every six months.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and civil defence supplies which are checked annually. The kitchen has gas and electric cooking and there is a gas BBQ available for alternate cooking. There is two-hour battery backup for emergency lighting. The facility is secure at night.</p> <p>A call bell system is in place. Missing was documented evidence to confirm that there is one</p>

		staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All bedrooms and communal areas have ample natural light and ventilation. Individual wall heaters are in resident rooms. There is underfloor heating in all communal areas. The communal areas were well ventilated throughout the audit. The facility has a small outside smoking area by the garden shed.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is the clinical coordinator/RN who has been in the role for one year. The infection control coordinator (ICC) oversees infection control for the facility and is responsible for the collation of infection events.</p> <p>The infection control programme was reviewed in October 2019. The infection control programme is appropriate for the size and complexity of the service.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There are sufficient supplies of personal protective equipment and a pandemic kit available. The residents are offered influenza vaccinations.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The infection control coordinator attended a study day at the DHB for infection control that covered standard precautions, personal protective clothing, isolation and cleaning procedures. The infection control coordinator has access to the GP, local laboratory, the infection control nurse specialist at Greenlane hospital, public health department and an aged care consultant for advice or support for infection control matters.
<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</p>	FA	Infection control policies and procedures have been developed by an aged care consultant and regularly reviewed. Policies include defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control.

<p>policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p><b>Standard 3.4: Education</b> The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator has completed relevant training and is responsible for coordinating/providing education and training to staff. Education is provided annually (March 2019). Hand washing competencies are completed on orientation and are ongoing.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p><b>Standard 3.5: Surveillance</b> Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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. Individual infection reports are completed for all infections. Graphs of infection events are provided. Definitions of infections are in place appropriate to the complexity of service provided. There is discussion around infection control data, trends or analysis and graphs are produced for staff information. There is close liaison with the GP that advises and provides feedback/information to the service. A monthly report is provided from the laboratory. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b> Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint policy in place that states the organisations philosophy to restraint minimisation (link 1.2.3.4). The restraint coordinator is the clinical coordinator. There were no residents using restraints or enablers. The orientation and staff education programme includes training on restraint minimisation.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	The owner/manager was not available during this audit and therefore his professional development relating to managing an aged care facility over the past 12 months was not able to be verified.	Documentation was unable to be sighted to confirm that the owner/manager has attended a minimum of eight hours of professional development relating to managing an aged care service.	<p>Ensure the owner/manager attends a minimum of eight hours annually of professional development relating to managing an aged care service.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures.</p>	PA Low	The document control system, as stated in policy, has not been implemented and the quality and risk plans have not been updated since December 2016. The facility signage and policies/procedures reflect the	(i) Policies and procedures were last reviewed either in March or June 2018 (prior to the new ownership) and are stated in policy that they will	(i) Ensure policies/procedures are reviewed in line with the document

<p>This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>		<p>facility's previous name.</p>	<p>be reviewed annually.</p> <p>(ii) The quality and risk plan was last reviewed in December 2016.</p> <p>(iii) Policies, procedures and signage around the facility reflect the facility's previous name and have not been updated to reflect Greenwood Rest Home.</p>	<p>control schedule.</p> <p>(ii) Ensure the quality and risk plan is reviewed/updated annually.</p> <p>(iii) Ensure policies, procedures and signage reflect the current name of the facility.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>Staff files were not available for reviewing during the audit. The clinical coordinator stated that files contain signed employment agreements, evidence of reference checking and police vetting, an applicable job description, performance appraisals and evidence of a completed orientation programme. The interRAI trained RN left in July 2019 and the clinical coordinator is not currently interRAI trained. Since the draft report a new RN has been employed that is interRAI trained.</p>	<p>Due to the owner/manager being quarantined, staff files were in a locked area and were not available for sighting.</p>	<p>Ensure that staff files are made available on request.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The clinical coordinator completes the initial assessments and support plans within 24 hours of admission. Long-term care plans were completed within 21 days of admission in the two files reviewed. InterRAI assessments had been completed, but not six monthly as required. The care plans had not been evaluated six monthly. Activity plans were in place, however these had not been evaluated six monthly.</p>	<p>(i) Two of two files reviewed did not have routine interRAI assessments completed six monthly.</p> <p>(ii) Two of two files reviewed did not have the care plans evaluated six monthly.</p> <p>(iii) Two of two files did not</p>	<p>(i) Ensure interRAI assessments are completed six monthly or sooner if required.</p> <p>(ii) and (iii) Ensure the long-term care plans and the activity plans are</p>

			have activity plans evaluated six monthly.	evaluated six monthly.  60 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	Long-term care plans were documented by the clinical coordinator. The clinical coordinator and HCA were knowledgeable about the individual resident care needs. The care plans documented the resident supports, however not all interventions were documented to guide care staff for medical conditions and clinical care.	One resident file did not reflect the risk and interventions needed for seizures. The same resident did not have any early warning signs and symptoms for a psychiatric illness and there were no interventions documented for unintentional weight loss.	Ensure the care plan has interventions and care documented for all resident needs.  60 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>	PA Low	Documentation sighted did not evidence that there is a first aid/CPR trained staff available 24/7.	Documentation held on site does not support evidence that there is a minimum of one first aid trained staff on site twenty-four hours a day, seven days a week.	Ensure that there is a minimum of one first aid trained staff available 24 hours a day, seven days a week.  90 days

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.