

Lifeline Agedcare Limited - Palm Grove Rest Home

Introduction

This report records the results of a Surveillance 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:	Lifeline Agecare Limited
Premises audited:	Palm Grove Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 March 2020 End date: 17 March 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	16

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

Palm Grove Rest Home is privately owned and operated. The service is certified to provide rest home level of care for up to 28 residents. On the day of the audit there were 16 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, management and staff.

The owner/director has responsibility for finances and non-clinical support services. He is supported by a facility manager who is newly appointed and is a registered nurse. The facility manager is also supported by another registered nurse on duty 30 hours per week.

There were 36 shortfalls identified at their last audit (provisional audit). Two findings were related to the prospective owner. The prospective sale did not proceed and therefore two previous shortfalls specifically related to a prospective new owner has been identified as 'not applicable' at this audit.

Twenty-one of 34 shortfalls have been addressed and included: communication, advance directives, business plan, policy for delegated authority, policies, document control, measurement of quality risk achievements, corrective action plans, essential notifications, human resources processes, education, skills mix policy, consumer information, integrated care, activities, care plan evaluations, food service, privacy signs and fire drills.

Improvements continue to be required around: communication of internal audit outcomes, review of hazard register, neurological observations, timeframes for assessments, assessments , care plan interventions, and, aspects of medicine management, planned maintenance, outdoor seating, cleaning processes, chemical storage, call bell system and external window.

This audit identified a further shortfall around self-medicating.

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>Standards applicable to this service fully attained.</p>
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Information regarding the service is provided on entry including the complaint policy. A complaints register is maintained, and complaints are seen as opportunities to improve service delivery. There are monthly resident meetings and six-monthly care plan meetings. Residents confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

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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There is a documented quality and risk management system that supports the provision of clinical care and support at the service. Staff review all aspects of the quality improvement and risk management system to ensure that any issues are identified and resolved. There are monthly quality and staff meetings.

There are human resource policies implemented around selection of staff, orientation and staff training and development. Staff and residents confirmed that staffing levels are adequate, and residents have access to staff when needed.

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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The registered nurse is responsible for the assessments, development and evaluation of care plans. There is input from the residents, staff and family members in the care plans. The general practitioner reviews the residents three monthly or earlier if required.

A variety of activities are coordinated by care staff allocated to activity hours Monday to Friday. The activities meet the resident preferences and interests as confirmed on resident interviews.

There is an electronic medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner every three months or as necessary according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met.

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 medium or high risk and/or unattained and of low risk.
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A current building warrant of fitness is in place. There is safe access to external areas. Privacy is ensured in communal toilets. A six-monthly fire drill has occurred.

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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The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. The facility manager is the restraint coordinator. There are currently no residents using enablers or restraint. Staff receive training in restraint and managing challenging behaviour as part of the annual training plan.

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 is documented. The infection control coordinator (facility manager) is responsible for coordinating education and training for staff. The infection control coordinator uses information obtained through surveillance 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	15	0	0	10	0	0
Criteria	0	38	0	2	13	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 1.1.10: 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>	<p>FA</p>	<p>There is an informed consent policy which includes a statement relating to advanced directives. Five resident files reviewed (including one younger person and one respite care) evidenced that advance directives had been signed appropriately and witnessed by the general practitioner (GP). The previous finding has been addressed</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	<p>FA</p>	<p>There is a complaints policy and flow chart to guide practice which aligns with Right 10 of the Code. The facility manager leads the investigation of concerns/complaints in consultation with the registered nurse and consultant if required. Concerns/complaints are discussed (as appropriate) at the monthly quality/staff meeting as sighted in the meeting minutes. Complaints forms are visible at the main entrance. There has been one complaint received by the DHB in May 2019 regarding provision and documentation of care needs and standard of cleanliness (link 1.3.3.1, 1.3.4.2, 1.3.5.2, 1.3.6.1 and 1.4.6.2). There have been no complaints for 2020 to date. A complaints log is</p>

<p>understood, respected, and upheld.</p>		<p>maintained.</p> <p>Residents interviewed know of the complaints process and stated management are very approachable. A complaints procedure is provided to residents within the information pack at entry.</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>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident. Nine accident/incident forms reviewed confirmed that family were notified following an accident/incident related to a resident and any changes to the resident's health status including infections, GP visits and medication changes. No family visited on the day of audit to interview. The previous finding around family notification of accident/incidents has been addressed. Resident meetings are held monthly and record a good attendance. Six residents interviewed stated they had an opportunity to discuss all areas of service including activities and food services as sighted in meeting minutes. The previous finding around resident meetings has been addressed.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The admission information (reviewed) and the admission agreement (sighted) contained the required information as per HDSS and the ARC contract. The previous finding around admission information and the admission agreement has been addressed.</p> <p>There is access to an interpreter service if required.</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>Palm Grove Rest Home provides rest home level of care for up to 28 residents. The service has three double rooms. However, resident rooms were of single occupancy on the day of audit. There were 16 residents including one younger person under disability support services and one resident for respite care.</p> <p>The service is privately owned. The owner/director is an accountant and is responsible for business, payroll, financial operations and maintenance. The building is leased. The owner/director is involved in the daily operations and is on site most days and was present on the days of audit. An independent consultant (RN) is contracted as required to provide oversight of quality risk management systems.</p> <p>The facility manager/registered nurse (RN) had only been in the role for four days. She has been working with accessibility for the last two years providing clinical oversight for ACC clients in their homes and previous to that was an RN working in aged care for two years. The facility manager resigned February 2020 and the previous facility manager (DT) returned to orientate and continue mentoring the new facility manager over the next three weeks. The DHB and HealthCERT were notified of change in manager. A registered nurse is employed from 10 am to 3 pm Monday to Friday.</p> <p>There is a current business plan in place 2019 to 2020 which includes the mission statement and values of the</p>

		<p>service. Key performance areas include finance, operations, residential facilities, business development, quality improvement, professional development. The governance group (the owner/director, manager and registered nurse) review the business plan against predicted targets. The previous finding around the business plan has been addressed. There is a quality and risk management plan 2018-2020 with activities and frequency of monitoring documented.</p> <p>The facility manager has commenced an orientation with a previously retired facility manger (non-clinical) and the independent consultant/RN. The facility manager has a current annual practicing certificate and current first aid certificate. Her interRAI training has lapsed and will require re-assessments to be completed.</p> <p>The owner/director liaises with the Quality Nurse for the Health of Older People at the DHB.</p> <p>The sale did not eventuate therefore the previous finding around a transition plan is not applicable.</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>	FA	<p>There is a delegated authority in the absence of the manager policy developed August 2019. The owner/director is readily available for non-clinical support. An independent consultant/RN is available for clinical advice or support. The RN has been in the role 6 months. The temporary manager (DT) submitted a Section 31 as there was no RN on duty for four morning shifts. An enrolled nurse and additional caregivers were rostered on duty. The new facility manager is an RN with aged care experience. The previous finding has been addressed.</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</p>	PA Moderate	<p>The facility has a quality and risk management plan (2018-2020) that has been reviewed to monitor the service progress against quality goals. Quality improvements and activities such as food services and activities are monitored and include resident feedback from meetings and internal audits. The previous finding around monitoring quality activities has been addressed. The previous finding related to the prospective owner quality risk management plan is not applicable as the sale did not go ahead.</p> <p>Policies had been reviewed to align with good practice and legislative requirements. Current policies and forms are held in hard copy accessible to staff. The RN consultant oversees the document control system. Staff interviewed stated they are informed when there are new/reviewed policies and required to sign a declaration of understanding form. The previous finding around policies and document control has been addressed.</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>Monthly quality data is collated including incidents/accidents, infections, medication errors, staff injury and complaints/concerns. Quality and staff meeting minutes evidenced discussion around trends, analysis and corrective actions. There are monthly graphs and charts displayed for staff. The previous finding around communication of quality data for accidents/incidents and infection control has been addressed, however there was no documented evidence of internal audit outcomes and corrective actions communicated to staff.</p> <p>There was a 2019 internal audit schedule in place. All internal audits since the provisional audit had been completed as per schedule. Corrective actions had been signed off, however there was no documented evidence of audit outcomes and corrective actions communicated to staff. The previous finding around internal audit corrective actions has been addressed.</p> <p>The resident survey was completed March 2019 with identified improvements around activities and food which have been ongoing. The 2020 survey is due.</p> <p>Health and safety are a set agenda at the quality and staff meeting minutes. Staff interviewed have an opportunity to raise any health and safety concerns. Hazard report forms are utilised for identified hazards. however, the hazard register had not identified all environmental hazards. Staff complete a self-learning health and safety package and have completed emergency planning and fall prevention education. The policies and procedures have been reviewed; however, the hazard register had not been reviewed annually.</p> <p>There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention strategies include an assessment of risk and documented falls prevention strategies in care plans including sensor mats.</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</p>	<p>PA Moderate</p>	<p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The service collects incident and accident data monthly and reports aggregated figures monthly to the quality and staff meeting. Monthly and annual comparisons are made. Trends and analysis data are considered. Eight incident/accident forms for January and February 2020 were reviewed. Neurological observations have not been completed for incidents that include unwitnessed falls. The previous finding remains. Accidents/incidents are recorded in the resident progress notes.</p> <p>There has been a section 31 in February 2020 relating to police assistance with a boarder in the facility. There have been no outbreaks to report.</p> <p>Discussions with the owner/director and facility manager identified that they were aware of essential notifications. The previous finding in regard to essential notifications has been addressed.</p>

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<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Five staff files reviewed included two recently employed staff. All files contained all relevant employment documentation including a signed contract; job description relevant to the role, reference checks including police vetting and completion of induction and orientation. Annual performance appraisals had been completed for staff who had been at the service a year. The sample size extended by two files to evidence long-serving staff had annual performance appraisals. The cook (qualified chef) is currently volunteering and has a signed volunteer agreement and volunteer induction while waiting for the work visa to be approved. The previous finding around recruitment and employment processes has been addressed.</p> <p>A record of current practising certificates is maintained for the RNs, GP, pharmacy, dietitian and podiatrist.</p> <p>The 2019 annual education planner had been completed which included food safety, outbreak management, medicine management and documentation. The 2020 education planner is being completed and has covered informed consent, restraint, continence management, complaints and personal cares to date. The education planner meets the training requirements. Education has been provided by the facility manager/RN (previously), RN consultant and gerontology nurse specialist. Annual competencies have been completed including medications and handwashing. Caregivers and RNs have the opportunity to attend DHB residential study days.</p> <p>The RN is interRAI trained. The newly employed facility manager/RN is due to complete retraining. There is a roving Careerforce assessor available to support caregivers to progress through Careerforce qualifications. The previous finding around education has been addressed.</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. The previous finding around the skills mix policy has been addressed, however the shortfall related to the prospective owner is now not applicable. Rosters sighted reflected that staffing levels meet the ARC contract for rest home residential aged care. There is a facility manager (RN) Monday to Friday who is also on call after hours. There is an RN on duty Monday to Friday from 10 am to 3 pm and also available on call. The rosters reviewed identified the RN on call. Rosters of care staff reflected healthy rostering. The roster is reviewed daily by the facility manager and extra staff are available to work if required, dependent on resident acuity and increased in occupancy.</p> <p>Morning duty: There is one caregiver from 7 am to 3 pm. There is also one caregiver from 10.30 am to 5.30 pm who completes morning cares, laundry and some cleaning duties.</p> <p>Afternoon duty: There is one caregiver on duty 4 pm to 12.00 am with an RN on call.</p> <p>Night shift: There is one caregiver on duty from 11.30 pm to 8 am and an RN on call. The nightshift caregiver completes cleaning duties in non-sleeping areas within the facility.</p>

		<p>The owner/director is on site most days and oversees non-clinical services and maintenance. There is a maintenance person who works three days a week for two hours a day.</p> <p>Residents and staff interviewed stated they felt there were enough staff on duty to meet the needs of the residents.</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' clinical records are located in an office upstairs which is accessed only by staff. Residents sign consent for names to be displayed on bedroom doors. A tour of the facility confirmed there was no resident information publicly visible by other residents or members of the public. The previous finding has been addressed.</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>	PA Moderate	<p>Medication policies and procedures are in place and these have been reviewed within the last year. The RN and caregivers who have completed medication competencies (sighted) and medication education including medimap. All medications were stored safely. There were no restricted medications. The locked medication trolley is kept in the dining room; however, the keys were not kept on the person responsible for administering medications. Regular medications are in robotic rolls and 'as required' medications in blister packs. 'As required' medications are checked for expiry dates three monthly. Medications are checked against the electronic medication chart and signed in as pack checked. Eye drops were dated on opening. The medication fridge temperature was monitored daily and within the acceptable range. There were no standing orders. There were no expired medications on the days of audit. Any expired medicines are returned to pharmacy for disposal. There was one self-medicating resident, however the self-medication competency had not been reviewed three monthly. Medication errors are reported on an incident/accident report and followed up by the RN or facility manager. Medications and any errors are discussed at staff meetings.</p> <p>The service uses an electronic medication system to administer medication. Medication administration was observed for two regular medications and one as required medication. The general practitioner reviews the medication charts three monthly. Caregivers are required to contact the RN before the administration of any 'as required' medications. The effectiveness of 'as required' medications is reported in the progress notes and at handovers. Resident photos and documented allergies were sighted on medication charts reviewed (five on medimap). A full sample of 10 charts was unable to be completed due to access difficulties. The respite care</p>

		resident did not have a medication chart or pharmacy prescription for the administration of medications. The service has addressed the previous audit shortfalls, however, a shortfall around medicine management remains an area for improvement.
<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>All meals at Palm Grove Rest Home are prepared and cooked on site. Currently there is a volunteer cook (qualified chef awaiting a work visa) who is on site Monday to Saturday (no set hours) to prepare and cook meals including home baking. The chef is supported by care staff who serve and do dishes. All staff have completed food safety training. There is a four-weekly menu which has been reviewed by a dietitian in September 2019 and signed off following corrective actions. The previous finding around the food safety training and menu review has been addressed. The cook receives a resident dietary profile for all residents. Dietary requirements are provided including a sodium free diet, diabetic desserts and pureed meals as required. Residents cultural preferences are met with many residents of Russian ethnicity. Dislikes are known and accommodated. Meals are served to residents in the adjacent dining room. Caregivers prepare breakfasts and the main meal is at midday. The tea meal is pre-prepared for the caregivers to heat and serve. Variations to the menu is recorded in the diary.</p> <p>There is a current food control plan that expires 13 November 2020. The fridge, freezer and end cooked/heated food temperatures are taken and recorded daily. Inwards goods have temperatures checked and recorded. The previous finding around temperature recording and records has been addressed. All dry goods and perishable foods were date labelled. A cleaning schedule for the kitchen is maintained by care staff on night shift including mopping of the kitchen and dining room floors. All electrical equipment had been tested and tagged. The previous finding around the cleaning schedule and electrical testing has been addressed.</p> <p>Resident meetings allow for the opportunity for resident feedback on the meals and food services generally. Residents interviewed stated there had been some improvements around the meals including consideration of their preferences.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>The initial assessments are based on information from the resident, family, GP, needs assessments and other allied professionals involved in the care of the resident. Risk assessments are completed on admission. The initial assessment is based on the outcomes of information obtained and risk assessments. The outcomes of the first interRAI assessment and routine six monthly interRAI assessments are reflected in the long-term care plans (link 1.3.3.3). Activity assessments reviewed were completed within three weeks of admission and goals care planned within the long-term care plan. Not all risk assessments had been completed on admission for residents with known risk/problems. Observations including weight had not been completed as part of the initial assessment for two long-term residents and one respite care resident. General practitioner information was not available for the respite care resident. The previous finding around assessments remains an area for improvement</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Long-term care plans (LTCP) for long-term residents were in place and were linked to interRAI triggers. Care plans reviewed identified resident goals and supports required to meet the resident needs; however, these were not all identified as part of the assessment process (link 1.3.4.2). Where there were acute changes to resident's health status, interventions were not always updated in the LTCP or a short-term care plan (STCP) developed.</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>	<p>FA</p>	<p>When a resident condition changes the registered nurse initiates a nurse specialist or GP review for any resident concerns. A family communication page in residents' files evidenced the relatives are notified of any health changes. Residents interviewed confirmed they were being kept informed on their health and had access to the GP as required. Staff stated they are made aware of any resident changes at handover and in the short-term care plans (link 1.3.5.2). Interventions have been implemented and the previous finding has been addressed.</p> <p>There were adequate dressing supplies sighted. There were no wounds on the day of the audit. There is access to a wound nurse specialist at the DHB if required. All staff have attended wound care and pressure injury prevention education.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist clinical advice is available as needed through the DHB.</p> <p>Monitoring charts are used to monitor a resident's progress against resident goals and/or short-term needs and include monitoring for blood pressure pulse, weight, bowel recordings, pain, behaviours, food and fluid intake and blood sugar levels. Residents changes are documented in progress notes.</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</p>	<p>FA</p>	<p>Caregivers are allocated two hours a day (either 9-11 am or 1-3 pm) on a rotating Monday to Friday roster for activities. Many families visit in the weekends. Caregivers interviewed enjoyed the interaction with the residents and each caregiver had different skills and abilities to add to the programme. The programme is planned a month in advance and includes resident references. There is an exercise therapist for two hours a fortnight with good resident participation as observed on day one of the audit. On day two, there was good participation at Bingo taken by a caregiver. Other activities include music, book and newspaper readings and walks. There are happy hours on Fridays with piano playing by one of the residents. There are regular pet therapy visits. Communion is offered and residents are supported to attend church services. The service has a seven-seater van and there are weekly</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>shopping trips.</p> <p>Residents have a choice of attending group activities. Care staff ensure those who prefer to stay in their rooms have their recreational needs supported. Resident meetings provide an opportunity for residents to feed back on the activity programme. Meeting minutes identified residents would like more outings and there is an action plan to provide more outings as discussed with the owner/director and facility manager. Residents interviewed were satisfied with the home activities provided.</p> <p>Each resident record reviewed included an activities assessment and activity plan (incorporated into the long-term care plan) that is reviewed six monthly (link 1.3.3.3). Attendance records and monthly progress notes are completed. The previous finding around the activity programme and activity documentation has been addressed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans reviewed (link 1.3.3.3) had been evaluated by the RN with input from the caregivers. There is a written evaluation that documents progress towards meeting the residents desired goals and identifies if the goals had been met or unmet for all categories of activities of daily living, risk and activities. The resident and/or family have the opportunity to be involved in the evaluation of the care plan and sign the care plan. The previous finding around evaluations and family involvement has been addressed. Care plans are updated as a result of changes identified through the evaluation process.</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>	<p>PA Moderate</p>	<p>The service displays a current building warrant of fitness which expires 21 August 2020. There is a part-time maintenance person (qualified builder) for up to 10 hours a week to carry out maintenance and repairs. The 2019 and 2020 planned maintenance plan to date has not been completed and there were internal and external areas requiring repair. Hot water temperatures are checked monthly, with the recent recordings exceeding 45 degrees in communal toilet/shower areas. The plumber was notified on the day of audit and a corrective action report sighted. Resident equipment has been calibrated and some equipment such as standing scales are replaced two yearly. The previous finding around calibration of resident related equipment has been addressed. Electrical appliances for the facility had been tested and tagged, however not all equipment belonging to residents had been checked for electrical safety including oil filled heaters. The previous finding around maintenance and electrical testing remains.</p> <p>Residents were observed to mobilise safely within the facility with the use of mobility aids as required. There was safe access to the external areas as sighted on a tour of the facility and grounds on the day of audit. Shade is provided by a large umbrella. There was outdoor furniture but two wooden chairs were unsafe to sit on. The previous finding around safe access to the outdoors and provision of shade has been addressed, however the finding around safe outdoor seating remains.</p> <p>Caregivers interviewed confirmed that there is adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</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>	<p>FA</p>	<p>There are adequate numbers of communal toilets and showers. Two bathrooms can accommodate mobility frames and/or shower chairs as needed. There is one smaller shower used by independent residents. Communal toilet/shower rooms have vacant/engaged signs in place. The previous finding around privacy signs has been addressed.</p>
<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>	<p>PA Moderate</p>	<p>Cleaning and laundry is completed by rostered caregivers however there was no cleaning schedule for the frequency of duties undertaken on the morning and nightshift. On the day of audit, there were carpets in at least four resident rooms that were badly stained and one room had a “musty” smell. Not all resident rooms were of a good standard of cleanliness. The previous finding around cleanliness and cleaning schedules remains.</p> <p>The laundry room is located in an external room which is locked when not in use. The caregiver on laundry and cleaning duties could describe the clean/dirty flow. Equipment used has been serviced and the laundry area can accommodate the laundering of personal clothing and linen. There were adequate supplies of linen, which was of reasonable quality, sited in linen cupboards. Residents were observed to be well dressed on the days of the unannounced audit. A laundry audit in September 2019 did not identify any areas for improvement. The chemical provider monitors the effectiveness of chemicals for cleaning and laundry services. The previous findings around laundry processes has been addressed; however there remains a finding around safe chemical storage.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>The facility’s flip chart includes a variety of possible emergency events such as: fire, earthquake, and flooding. There are emergency management policies and procedures in place. Staff induction includes emergency events including fire safety. All staff have completed first aid training. A fire drill was last conducted in November 2019 and scheduled for May 2020. The previous finding around drills has been addressed.</p> <p>The call bell system at the facility comprises of telephones that link to staff pagers. The call bell system is not</p>

<p>an appropriate and timely response during emergency and security situations.</p>		<p>integrated therefore calls are not responded to in a timely manner. The previous shortfall remains an area for improvement.</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>PA Moderate</p>	<p>The environment in the home was comfortable on the days of audit with opening doors and windows for ventilation. Residents interviewed were satisfied with the temperature of the facility. Heating in winter is provided by wall panel heaters, heat pumps and free-standing oil filled portable heaters in resident rooms; however not all heaters have been electrically tested (link 1.4.2.1). The residents' lounge has a heat pump. The finding around heating and ventilation has been addressed.</p> <p>One resident's room has an internal window which opens into the manager's office. External ventilation of this room is provided by an external window on the outer wall of the manager's office. This is kept open with security stays to provide ventilation to the resident room but there is no external window allowing natural light into the room. The previous finding around an external window remains.</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 (facility manager) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Monthly infection events are collated, graphed and analysed for trends and corrective actions. Infection control statistics are reported at the quality and staff meetings on a monthly basis. Meeting minutes confirmed discussion around issues and trends. Care staff interviewed confirmed infection control and surveillance data is discussed and meeting minutes available. The GP also monitors the use of antibiotics.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers in the relevant policy. The policy identifies that restraint is used as a last resort and staff interviewed confirmed this.</p> <p>The facility manager is the restraint coordinator. Staff received training in restraint annually and challenging behaviour was provided in April 2019. Staff complete an enabler and restraint competency.</p>

restraint is actively minimised.		There are no residents with enablers or restraints in use.
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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Moderate	The facility conducted internal audits as per the 2019 and 2020 audit schedule to date. For results less than expected a corrective action is developed and signed off when completed, however the results are not communicated to staff. Satisfaction survey results have been provided to residents/staff.	The results/outcomes and corrective actions of internal audits are not communicated at staff meetings.	<p>Ensure the outcomes and corrective actions of internal audits are communicated to all staff.</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their</p>	PA Moderate	There is a facility hazard register which has not been reviewed on the due date of January 2020. Not all identified hazards and controls had been included in the register.	The hazard register is not current and has not been reviewed on due date.	Ensure the hazard register is current and reviewed

<p>family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>				<p>annually.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>When a resident falls and this is unwitnessed, protocol states neurological observations will be completed unless the resident states, they did not knock their head. Review of incidents/accidents for unwitnessed falls evidenced the required neurological observations were not always completed.</p>	<p>Neurological observations had not been completed as per protocol for four of four unwitnessed falls reviewed.</p>	<p>Ensure neurological observations are completed for unwitnessed falls.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>Medications are stored in a locked medication trolley in the dining room and in an upstairs cupboard outside the nurse's office. The medication person was not carrying the keys on the day of audit. The service uses an electronic medication system for long-term residents; however, this is not always used for respite care residents and there was no medication chart (electronic or paper-based) for the respite care resident.</p>	<p>(i) The medication keys were being kept in a drawer in the dining room accessible to all staff.</p> <p>(ii) There was no medication chart or pharmacy prescription for the administration of medications for the respite care resident.</p>	<p>(i) Ensure the medication keys are kept on the person responsible for the administration of medications.</p> <p>(ii) Ensure there is a medication chart or current pharmacy</p>

				<p>prescription for the administration of medications for respite care residents.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	There is one self-medicating resident for eye drops as prescribed. There had been a self-medication competency completed; however, this had not been reviewed three monthly.	The self-medication competency had not been reviewed since October 2019.	<p>Ensure self-medication competencies are reviewed three monthly.</p> <p>60 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>	PA Moderate	The RN is responsible for assessments, care plan development and evaluation of care plans for long-term residents. Not all care plans (including the activity plans) had been developed within the required timeframes and not all interRAI assessments had been completed six monthly.	<p>(i) One long-term care plans was not developed within three weeks of admission.</p> <p>(ii) One resident file reviewed did not have the interRAI assessment completed six monthly and the long-term care plan, including the activity plan had not been evaluated six monthly.</p>	<p>(i) – (ii) Ensure long-term care plans, six monthly interRAI assessments and long-term care plan evaluations are completed within the required timeframes.</p> <p>30 days</p>

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>Five paper-based resident files were reviewed including one younger person under disability support services and one respite care resident. All files reviewed (including the respite file) identified an initial assessment and support plan which had been completed on admission. Overall, the outcomes of the first interRAI assessment and routine six monthly interRAI assessments were reflected in the long-term care plans. However, not all risk assessments had been completed on admission for residents with known risk/problems. Observations including weight had not been completed as part of the initial assessment for two long-term residents and one respite care resident. General practitioner information was not available for the respite care resident.</p>	<p>(i) There was no medical information obtained for the respite care resident and a behaviour assessment had not been completed as the resident was a wandering risk.</p> <p>(ii) There were no pain assessments completed for; (a) one resident admitted on restricted medication for pain management, and (b) one resident with a new pain requiring GP review and analgesia.</p> <p>(iii) Admission observations including weight had not been completed for three residents (two long-term and one respite care).</p>	<p>(i) Ensure initial assessments include available medical information.</p> <p>(ii) Ensure risk assessments and pain assessments are completed for known risks/problems.</p> <p>(iii) Ensure observations including weight are completed on admission.</p> <p>60 days</p>
<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>	<p>PA Moderate</p>	<p>Two of four long-term care plans were linked to interRAI triggers. Overall care plans reviewed identified resident goals and supports required to meet the resident needs; However, care plans were not updated or a STCP developed for two residents with changes in health status and a medication risk was not documented for one resident.</p>	<p>Care plan interventions were not updated in the LTCP or a STCP developed for; (i) a resident with 3kg weight loss since admission, (ii) a resident with new</p>	<p>(i) Care plan interventions are updated in the LTCP or a STCP developed; and (ii) Ensure medication</p>

			<p>pain as per GP notes and progress notes. The same resident did not have the risks of Warfarin documented in the care plan.</p>	<p>risks are documented in care plans.</p> <p>60 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>Facility electrical equipment checks have been completed, however not all resident related electrical equipment in resident rooms had been checked for electrical safety. Resident related medical equipment had been calibrated. Hot water temperatures in communal shower/toilet/handbasins were recorded as high as 52 degrees and corrective action was taken on the day of audit. A maintenance log is maintained for repairs, however there were several internal and external areas that require repair and a completed planned maintenance schedule was not available.</p>	<p>(i) Resident related electrical equipment in bedrooms have not been routinely checked for electrical safety including oil filled heaters.</p> <p>(ii) A preventative maintenance schedule is not implemented to ensure the safety of residents and eliminate hazards including lifting floorboards outside the doorway to two communal toilets, one external exit door does not close properly and some external corners of the building are sharp and hazardous to residents.</p>	<p>(i) Ensure electrical checks are conducted for resident equipment.</p> <p>(ii) Ensure preventative and planned maintenance is completed.</p> <p>60 days</p>

<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA Moderate</p>	<p>There is safe access for residents to the internal courtyard and other outdoor areas. Residents were observed to be using the outdoor areas on the day of audit. There is outdoor furniture and an umbrella to provide shade however not all seating was safe to use. The previous finding around safe access to the outdoors and provision of shade has been addressed however the finding related to safe outdoor seating remains.</p>	<p>There were two wooden outdoor seats that were unstable and unsafe to use.</p>	<p>Ensure outdoor seating is safe to use.</p> <p>60 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Moderate</p>	<p>Cleaning and laundry are completed by a caregiver on the 10.30 am to 5.30 pm shift. Cleaning in non-sleeping areas is done by the night shift caregiver. On the day of audit, there were carpets in at least four resident rooms that were badly stained and one room had a “musty” smell. Not all resident rooms were of a good standard of cleanliness. There is no cleaning schedule in place to monitor cleaning duties. A cleaning audit in December 2019 identified the dining rooms floors were not being mopped regularly and this was now on the night shift duties; however, there is no nightshift cleaning duties schedule.</p>	<p>(i) There were no cleaning schedules in place to monitor the frequency and completion of cleaning duties. (ii) Internal cleaning audits are only completed annually.</p>	<p>(i) Ensure cleaning duties are scheduled and completed.</p> <p>(ii) Audit cleaning services more frequently.</p> <p>60 days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Moderate</p>	<p>Chemicals are supplied by an external contractor and stored in the laundry until ready for use. There is a dispensing system for chemicals inside the kitchen entrance. Chemicals are in approved spray bottles with manufacturer labels. Safety data sheets are available. Staff completed chemical safety training September 2019. Cleaning chemical spray bottles are accessible to residents and visitors at the tea/coffee making area outside of the kitchen. The cupboard was not lockable. Chemical bottles were seen on the bench top where drinks were made. The finding</p>	<p>Cleaning chemicals were observed to be accessible to residents and visitors.</p>	<p>Ensure safe storage areas are provided for chemicals.</p> <p>60 days</p>

		around safe chemical storage remains.		
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>The call bell system at the facility comprises of telephones that link to staff pagers. Other resident rooms (toilet/shower room) and communal areas (lounge) had a press call bell system that was heard but not linked to the staff pager. Several tests of the system did not raise a response from staff. When repeated in the resident rooms using the telephone system the room numbers did not correspond with the bedroom number. The previous finding around the call bell system remains.</p>	<p>The call bell system is not integrated therefore calls are not responded to in a timely manner.</p>	<p>Ensure there is an effective call bell system in place to summon assistance.</p> <p>30 days</p>
<p>Criterion 1.4.8.1</p> <p>Areas used by consumers and service providers are ventilated and heated appropriately.</p>	<p>PA Moderate</p>	<p>Heating in winter is provided by wall panel heaters, heat pumps and free-standing oil filled portable heaters in resident rooms; however not all heaters have been electrically tested (link 1.4.2.1). There is one resident room without an external window. While the previous ventilation concern has been addressed the rooms does not have an external window allowing natural light into the room. .</p>	<p>There is one resident room without an external window.</p>	<p>Ensure all resident rooms have one external window allowing for natural light to enter the room.</p> <p>90 days</p>
<p>Criterion 1.4.8.2</p> <p>All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.</p>	<p>PA Low</p>	<p>One resident's room has an internal window which opens into the manager's office. External ventilation of this room is provided by an external window on the outer wall of the manager's office. This is kept open with security stays to provide ventilation to the resident room.</p>	<p>One resident's room only has an internal window</p>	<p>Ensure all resident rooms have external windows</p> <p>180 days</p>

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.