

# South Care Limited - South Care Rest Home & Hospital

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## Introduction

This report records the results of a Provisional 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 The DAA Group 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>	South Care Limited
<b>Premises audited:</b>	South Care Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 2 November 2020      End date: 2 November 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>	39

# 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.

## General overview of the audit

Woodhaugh is privately owned and provides rest home and hospital level care for up to 70 residents. On the day of audit there were 39 residents.

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

The director/facility manager (non-clinical) is on site forty hours a week and has attended training related to the management of an aged care facility. He is supported by a clinical manager (registered nurse) who has been in the position for almost a year. They are supported by registered nurses and staff. Staff receive education and have policies and procedures in place to guide them in the safe delivery of care.

This audit identified areas for improvement around discussions in meetings, timeliness of assessments, care planning and evaluations, wound management, medications, food services, and infection control.

Provisional Audit: 02 November 2020

South Care Limited (SCL) has signed a sale and purchase agreement with Otago Care Limited to purchase Woodhaugh Rest home and Hospital. The anticipated settlement date is 28 November 2020. The Ministry of Health (MoH) HealthCert, have approved this provisional audit to be conducted off site using the findings (contained in this report) from Woodhaugh's most recent (August 2020) re-certification audit.

Evidence to establish the preparedness and suitability of SCL (the prospective provider) was derived from two telephone interviews with a director from SCL, and a review of their transition plan and other documents provided as part of the process.

The directors of SCL have been working on site at Woodhaugh since 05 October 2020 following discussions and approval from Southern District Health Board (SDHB), the MoH and an agreement with the current owner. They are ensuring safe delivery of care services to the residents and establishing new staffing regimes. For example, they have appointed a lead registered nurse and one of the directors has assumed the role of clinical services manager. Being on site means they have been able to implement systems they consider a high priority and carry out due diligence checks prior to settlement.

There were no areas of concern identified during this off-site audit. SCL have proven competence and experience as operators of aged care services in New Zealand. They demonstrate readiness to takeover Woodhaugh Rest home and Hospital, which will be trading as South Care Rest Home and Hospital as soon as settlement and approval from MoH has occurred. Southern District Health Board are aware of the proposed change of ownership and the yet to be progressed corrective actions identified at the August certification audit. There were two areas identified subsequent to that audit which do not appear to meet these standards. For example, in quality and risk, and the building. South Care Limited will be addressing these with Otago Care Limited and/or the DHB and MoH prior to settlement.

## **Consumer rights**

Woodhaugh provides an environment that supports resident rights. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## **Organisational management**

The service has a documented quality and risk management system. Services are planned, coordinated, and are appropriate to the needs of the residents. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The director/facility manager is supported by a clinical manager who is a registered nurse who is on site five days a week and is on call when not on site. They are supported by a team of RNs.

There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

## **Continuum of service delivery**

Meals are prepared on site and provided to two dining rooms. The menu is developed under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for.

The clinical manager has primary responsibility for managing entry to the service. An information pack is available prior to or on entry to the service. Registered nurses' complete initial assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process. General practitioners review residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers and community interactions.

Medicines are stored and managed appropriately in line with legislation and guidelines. Registered nurses administering medications have completed annual competencies. The general practitioners reviewed the medication charts at least three monthly.

Meals are prepared and cooked on site under the direction of the experienced cook. A food control plan is in place. The menus are reviewed by a dietitian. The menu is varied and provides meal options. Individual and special dietary needs are catered for.

## **Safe and appropriate environment**

The building has a current warrant of fitness. All rooms are single use and are personalised. There are some rooms with ensuites and a number of shared mobility bathrooms. There are communal toilets located close to the communal areas. There are heaters available to keep the rooms warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction. Outdoor areas are safe and accessible and provide seating and shade for residents.

There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. There are documented policies and procedures for the cleaning services that are implemented with monitoring systems in place to evaluate the effectiveness of these services. All chemicals are stored safely, and the laundry is well equipped. The cleaning service maintains a tidy, clean environment. There is an emergency evacuation plan in place and sufficient civil defence supplies. There are first aid trained staff members on duty at all times.

## **Restraint minimisation and safe practice**

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. Woodhaugh has been restraint free since August 2019. On the day of audit, the service had no residents using restraint or enablers.

## **Infection prevention and control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a range of policies, standards and guidelines, training and education of staff and scope of the programme. Covid 19 policies and procedures including an outbreak management plan have been developed.

## 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	37	0	6	2	0	0
<b>Criteria</b>	0	85	0	6	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 staff at Woodhaugh ensure that all residents and families are informed about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There are posters displayed in visible locations. Policies around the Code are implemented, and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education last held in August 2019. Interviews with staff (nine healthcare assistants, two registered nurses, one facility manager, one clinical manager and one diversional therapist), reflected their understanding of the key principles of the Code.</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</p>	FA	<p>There was informed consent policies, procedures and advance directives in place. The resident or their enduring power of attorney (EPOA) signs for written general consents including outings and indemnity. Signed admission agreements and general consent forms</p>



<p>choices and give informed consent.</p>		<p>were sighted in the seven resident files sampled. There was evidence in files sampled of family/EPOA discussion with the GP for medically indicated not for resuscitation status where residents were not deemed to be competent.</p> <p>In the files sampled, there was an appropriately signed resuscitation plan and advance directive in place. Discussions with residents and family/whānau where appropriate, and client files demonstrated they are involved in the decision-making process and in the planning of the resident's care.</p> <p>Discussions with staff confirmed they are familiar with the requirements to obtain informed consent for entering rooms and personal care.</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>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the reception area. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff interviewed know where to access the leaflets and information around advocacy services. A member of Age Concern facilitates the resident meetings.</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>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit in accordance with the Covid 19 regulations. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. Resident meetings are held two monthly.</p> <p>There are regular outings into the community. Community groups visit the home as part of the activities programme as current regulations allow. Residents attend the epilepsy group and church services in the community. Residents verified that they have been supported and</p>

		encouraged to remain involved in the community where appropriate.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy in place. The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Five complaints have been logged year to date since the previous audit in August 2019. All complaints are acknowledged, and a comprehensive investigation is completed, the complainant is kept informed if a lengthy investigation delays timeframes. A follow-up letter is sent to the complainant or a meeting is held to discuss the complaint and outcome of the investigation. Complaints all included a section to confirm that the complainant was happy with the outcome. The complaint was signed off on the register once resolved.</p> <p>There have been no health and disability complaints since the last audit. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. Staff interviewed confirmed complaints are discussed at meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. The clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission. Leaflets on the code and advocacy services are available in the reception area.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All nine residents (five hospital and four rest home) and three relatives (three hospital) interviewed, reported that the residents' rights are being upheld by the service.</p>

		<p>Provisional Audit</p> <p>The South Care Limited (SCL) director interviewed, demonstrated thorough knowledge and understanding of the Code and its requirements, and described various methods for implementing and monitoring adherence to the Code in everyday practice. SCL own and operate two other aged care facilities in New Zealand, and the directors and their executive team have attended education on the rights of residents (the Code) and are diligent in ensuring their care staff uphold these rights. The director confirmed there was sufficient information available on site and that the processes already in place meet the requirements and the needs of residents. These included having an external advocacy agency facilitate the six weekly residents' meetings. The prospective provider/SCL intends continuing these already established methods.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>It was observed that residents are treated with dignity and respect. Residents and family interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training in August 2019.</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.</p> <p>There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. Management liaise with the kaumātua service through Hospice for any support or guidance required.</p> <p>There were two residents who identified as Māori. One resident was</p>

		<p>hospital level and had no involvement or affiliation with their culture. The staff were supportive of this choice. The other resident had been a respite resident, who was palliative and had the kaitakawaenga. The hui was held (during the audit) to welcome him as a permanent resident. The Māori representative worked at the hospice and was very positive about the service.</p> <p>Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic, which was last offered in August 2020. All healthcare assistants interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</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 and values from the time of admission. This is achieved with the resident, family, and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</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>A staff Code of Conduct/house rules is discussed during the new employees' induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities. Healthcare assistants also described how they build a supportive relationship with each resident. Staff were observed to be professional when carrying out their duties. Residents and the relatives interviewed stated they are treated fairly and with respect by staff.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24-</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>hours a day. Each resident can choose to retain their own general practitioner (GP), however most residents choose to utilise the house GP, who visits on a regular basis and is available after hours. Woodhaugh has been restraint free since August 2019.</p> <p>Physiotherapy and dietitian services are provided as needed following a referral. A podiatrist is on site every three to four weeks. The nurse practitioner (NP) for mental health (interviewed) is involved with the service and reported the staff and management do their best for the residents, especially the residents with complex needs. The GP and NP reported during interviews that referrals to other services are timely and appropriate.</p> <p>Woodhaugh support healthcare assistants to achieve qualifications, and there is a regular in-service education and training programme for staff. The registered nurses have access to the Hospice and the DHB for external training sessions and study days. The service has links with the local community and encourages residents to remain independent.</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>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen electronic accident/incident forms were reviewed (from August 2020) which identified relatives are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</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 residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p>

<p><b>Standard 1.2.1: Governance</b></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>Woodhaugh rest home provides residential services for up to 70 residents requiring rest home or hospital (geriatric or medical) level care. There are 31 dual-purpose rooms and 39 rest home only beds. On the day of the audit, the Gables wing (the upstairs wing) had been refurbished and has been signed off as safe for residents to use, this area was not in use at the time of the audit. The clinical manager has a list of designated dual-purpose rooms.</p> <p>On the day of audit there were 39 residents – 19 at rest home level care including one on a younger person with disability contract and one on respite care and 20 at hospital level of care including two on respite care and one resident on a long-term support chronic health contract. All hospital level residents reside in verified dual-purpose rooms, except two residents who have chosen to reside in rest home rooms. These rooms provide adequate space for resident cares to be provided as sighted during the audit. Showers and toilet facilities are located within easy distance of these rooms. There are two double rooms which have been previously verified. One room is occupied by a married couple, the other was vacant.</p> <p>The non-clinical facility manager purchased Woodhaugh in October 2017 and took over the manager role in March 2018. The manager provides organisational oversight and management of the facility. He is supported by a clinical manager (CM) who has been in the role for one year. She is a registered nurse with experience in aged care and management. They are supported by an administrator, registered nurses and healthcare assistants.</p> <p>The goals and direction of the service are documented in the annual business, quality and risk plan.</p> <p>The manager has completed eight hours of education related to the running of an aged care facility.</p> <p>Provisional Audit</p> <p>The business will be owned by South Care Limited and will trade as South Care Rest Home &amp; Hospital. The directors of SCL already own and operate two aged care facilities. A rest home with dementia care in</p>

		<p>Eltham purchased in 2017, and a rest home/hospital service in Whangarei purchased in 2019. Both directors are RNs with current practising certificates and extensive experience as nurses, clinical managers and facility managers in the New Zealand aged care sector.</p> <p>The sale and purchase agreement is for buying the care services only. The buildings and fixtures will remain the property of Otago Care Ltd with an option for SCL to purchase if they choose to in the future.</p> <p>The directors of SCL have a proposed long term organisational structure and have already implemented a short term chain of command which includes the two nurse directors, both of whom have been working on site as the facility manager and clinical services manager since 05 October 2020. SCL had been contracted to provide consultancy services for the business and care services and began overseeing the day to day operations, including quality and business risk and clinical care in agreement with the current owner and SDHB to preserve the business and ensure safety for residents and staff. They are also working toward closing off the eight corrective actions identified during the August 2020 recertification audit.</p> <p>Long term, the documented organisational structure shows one director as the 'roving' national general manager who will be supporting three facility managers. The other director will be the national quality manager responsible for oversight of quality assurance and risk mitigation.</p> <p>South Care Limited state the transition period will be managed between themselves and the current owner to ensure the least amount of stress and anxiety for residents and relatives and with minimal disturbances on staff routine. They expressed no immediate plans to change the service size or configuration. In the longer term, that may consider adding dementia care services if there is a local demand and perhaps acquire a day activities programme contract. Their opinion is that the recently refurbished upstairs area is not suitable for provision of hospital care although these rooms had been approved as dual-purpose rooms. Refer to standard 1.4.2 for more detail.</p>
Standard 1.2.2: Service Management	FA	The service employs a clinical manager/registered nurse who is employed full time. The clinical manager takes on the manager's role in

<p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>the temporary absence of the facility manager.</p> <p>Provisional Audit</p> <p>As described above, SCL will operate the facility/home using the same systems it has in place for their two other homes. Currently the facility manager is the RN/director of SCL and this person will stay on site until a new FM is recruited and settled in the role. After that, the new CSM will be nominated second in charge and the lead RN (already established role) will step up to cover the CSM role during any times the CSM is acting up as the FM.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice. A document control system is in place. Policies are regularly reviewed. The manager is responsible for policy reviews with input from the clinical manager. There is also a quality consultant who acts as a clinical advisor including policy review when required. The manager facilitates the quality programme which includes internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Corrective action plans have been developed, implemented and signed off when service shortfalls have been identified. Quality improvement data is discussed at monthly registered nurse/quality meetings and the monthly staff meetings, however, there is no evidence of trending and analysis of quality data or infection control data discussed at meetings.</p> <p>There is a current risk management plan for 2020 in place which is reviewed annually. Goals are reviewed and progress is evaluated and signed off once complete. Improvements which have been completed since the previous audit include the completion of the Gables (upstairs) wing, the purchasing of ten hospital beds, refreshing and refurbishing resident rooms as available, shower rooms have been refurbished and refreshed, the outdoor areas have been upgraded, and the roof has been repaired. The activity programme has been reviewed; the diversional therapist has attended training at another facility to provide a more meaningful programme. Residents provide feedback to the diversional therapist regularly and through meetings. The housekeeping</p>



	<p>hours have been increased, there is now a housekeeper on both the north and south sides of the building daily.</p> <p>Resident meetings are held six weekly and are facilitated by Age Concern. The meeting minutes documented residents use the opportunity to provide feedback around meals and activities and feel comfortable discussing issues and compliment the staff for their hard work. Residents have been provided with information and updates during the Covid period and reported they were well informed during this time.</p> <p>The health and safety officer (manager) attended external health and safety training in 2020. The hazard register is stored online and includes required actions and was last reviewed in December 2019. The committee comprising of the diversional therapist, one housekeeper, the cook, and management meet monthly, the minutes of the meetings and actions are discussed at the registered nurse/quality, and staff meetings.</p> <p>There are resident and relative surveys conducted and analysed with corrective action plans developed when required. The 2020 survey is due to be completed later in the year. The 2019 resident and relative surveys demonstrated satisfaction in most areas. Individual concerns were addressed. A corrective action plan identified that improvements are being addressed in areas where results were of lower satisfaction.</p> <p>Falls prevention strategies include an investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Other strategies include sensor mats, and regular checks on residents at risk of falling.</p> <p>Provisional Audit</p> <p>South Care Limited will introduce the same quality system (including policies and procedures) used in their two other aged care facilities. This is a generic system which reflects the principles of continuous quality improvement (CQI), is tailored for the age care sector and moderated by the external owner of the programme. It includes regular internal audits, systems for analysis and reporting of quality data, such as trends in incidents/accidents, complaints, infections and restraint interventions, and providing regular opportunities for resident, family and other</p>
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	<p>stakeholder feedback.</p> <p>The transition plan states that all policies and procedures will be slowly incorporated over the first 12 months under the new management. There will also be a quality assurance person on site and a national quality manager who ensures all quality activities are being carried out and implemented effectively.</p> <p>The director stated that there appears to be large gaps in the policy and procedure system. They stated that very few policies can be found on site. There is also no evidence of a quality plan. South Care Limited have submitted a goal-oriented quality plan with specific aims and objectives for 2020-2022 designed for essential quality improvements. These include a review of food services, pursuant to a new chef (due to commence work soon) and implementing a new menu. This will assist in rectifying the corrective action in standard 1.3.13. Other continuous quality improvement (CQI) projects include relocation of the medication room and staff room, expansion of sluice rooms, improvements to the activities programme (extra staff and purchase of a van for outings), enhancing the outdoor environment, ensuring staff competence, remedying the call bell system and installing fire doors that meet the building code, plus any other matters that require urgent actions for resident and staff health and safety.</p> <p>The directors are already working on remedying the corrective action identified in August about analysing quality data for trends and ensuring service deficits/gaps are closed off and reported. The date for submitting evidence of actions specified by Southern District health Board is 15 January 2021.</p> <p>There appears to be some concern about the effectiveness of the electronic/computer system used for all recording and documentation. The prospective provider intends reviewing this within the first three months of ownership with a view to introducing a package of software designed for aged care services. This is further discussed in 1.2.9</p> <p>South Care Limited demonstrated that they have the skills, experience and knowledge to implement effective quality and risk management systems according to the principles of continuous quality improvement and which also adhere to current health and safety legislation.</p>
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<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>Individual electronic reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is collated monthly and discussed at meetings (link 1.2.3.6). Fifteen resident-related accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Relatives are informed of incidents. Neurological observations are conducted for suspected head injuries and all unwitnessed falls. Incident reports document opportunities to minimise the risks of future incidents and consider the reason for the incident such as possible infection.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been four notifications made to the ministry of health (MOH) since the previous audit.</p> <p>There have been no outbreaks since the previous audit.</p> <p>Provisional Audit</p> <p>Interview with a director of SCL confirmed that the prospective provider has sound knowledge and understanding about the requirements for adverse event reporting including Section 31 notifications. The transition plan describes a thorough analysis of all potential and actual risks with the current service, and actions are being taken to mitigate these and/or negotiate remedial actions prior to take over (refer to comments in 1.2.9 and 1.4.2). The director expressed some concerns about the current incident reporting system and the number of incidents. There were 27 reported incidents in October 2020 (for 39 residents) many of which were unwitnessed falls and there was limited evidence that neurological observations were always carried out post falls. This has since been rectified and mitigated. All accidents and incidents are reported via the electronic system. There is a stated intention to review the electronic system. Refer to standard 1.2.9</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>files reviewed (the clinical manager, two registered nurses, two healthcare assistants, the activities assistant and the cook) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates was maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: restraint, manual handling, hand hygiene, cultural safety and medication).</p> <p>There is an annual education and training schedule being implemented. The healthcare assistants undertake aged care education (Careerforce). Education and training for clinical staff is linked to external education provided by the district health board. RN-specific training viewed included: syringe driver, and wound care.</p> <p>There are three healthcare assistants with level 4 New Zealand Qualifications Authority (NZQA), five with level 3 and four at level 2. Three healthcare assistants are completing level 3 and two completing level 4. Woodhaugh are currently sourcing another Careerforce assessor. Eight staff employed in the last year have yet to enrol for NZQA.</p> <p>The clinical manager has not yet completed the required training due to Covid 19 restrictions.</p> <p>Provisional Audit:</p> <p>Review of the transition plan, staff training plans and interview with SCL confirmed that the prospective provider understands the importance of ongoing education, and competency assessments for all levels of staff. The two-year staff education plan submitted includes all expected and necessary training topics.</p> <p>The prospective provider has already started implementing their systems for recruitment, employment and performance management</p>
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		because they have had to recruit for specific roles.
<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>There is a staffing rational and policy, staffing levels meet contractual requirements. The manager/owner and clinical manager (RN) are on site Monday to Friday. There is at least one registered nurse on each shift.</p> <p>They are supported by six healthcare assistants on the morning shift; 2x 6.50 am to 3 pm, 2x 7 am to 11 am, and 2x 7.30 am to 2 pm.</p> <p>The afternoon shift has five healthcare assistants; 2x 2.50 pm to 11 pm, 2x 3.30 pm to 10 pm and 1x 3 pm to 10 pm.</p> <p>The night shift has two healthcare assistants from 11 pm to 7 am.</p> <p>A restructuring plan was developed in March 2020 with proposed changes to the rostering to a four on/two off basis to reduce staff burnout and share the weekend shift amongst staff to provide experience, promote team morale and teamwork. Shifts were adjusted to provide cover during busy times during shifts between 7 am and 10.30 am and 5 pm to 8 pm. Handovers planned to be streamlined and staff were to be provided with a handover sheet relevant to resident allocation. This proposal was put forward to staff for review and choice of shift patterns. Staff had the opportunity to provide feedback on the initial proposal and proposed rosters. During interview with staff, both morning and afternoon staff confirmed there was adequate staff on duty. Relatives and residents interviewed confirmed staffing was satisfactory.</p> <p>Provisional Audit</p> <p>Review of the current allocation of staff (sighted roster) and the roster proposed by SCL Ltd, showed that the prospective provider will allocate more hours and more staff on most shifts. This includes having an additional RN on site five days a week including a Saturday. A full time RN lead has already been appointed. Recruitment is underway for another full-time activities person, a full-time employed maintenance person and additional kitchen staff - an afternoon cook.</p> <p>During interview, the director stated that there were currently no maintenance people employed, although the evidence in standard 1.4.2</p>

	<p>states there were maintenance staff on site for four days a week. The former clinical manager recently resigned abruptly and the other director who is an experienced and qualified RN has taken on the role until another clinical manager commences employment.</p> <p>The transition plan and interview further described the following on site organisational structure with clear job descriptions for each position:</p> <p>A full time employed facility manager will be in-charge of the facility's operation and all business matters.</p> <p>A full-time clinical manager responsible for continuity and improvement of quality nursing service.</p> <p>A full-time quality assurance person to implement quality and risk management systems locally and ensure residents' care plans are reviewed on time and as appropriate. This person will also likely oversee staff education and ensure that all staff maintain competencies in care delivery.</p> <p>An additional full-time RN position, nominated as the nurse lead, will ensure that registered nurses are supported in their role. As stated above, this position has already been established.</p> <p>Registered nurses will be responsible for residents' health, safety, and overall well-being as their highest priority. RNs will ensure that all work delegated to the healthcare assistants (HCAs) are followed through. Healthcare assistants will remain as the first point of contact of care and will liaise with the RNs to share information regarding residents' care. The proposed rosters showed small increases in RN and HCA hours for each shift and an additional HCA allocated for each evening shift</p> <p>A full-time diversional therapist (DT) will ensure that activity planning for all clients are individualised and appropriate. Another full-time activity person will be employed to work together with the DT to ensure that the activity plan is adhered to and that each resident's social growth is given a great deal of importance.</p> <p>A full-time maintenance person will be recruited to manage buildings and equipment, and carry out planned and reactive maintenance as required. External contractors will be brought in as necessary.</p> <p>A full-time chef has been identified and will resume duties shortly to</p>
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		<p>manage food and nutrition services. The menu requires review, and this is planned to occur shortly using another external chef and dietician as improvement in this area is a high priority. Another kitchen hand will be employed to work side by side with the chef to ensure continuity of good food service delivery.</p> <p>The cleaner's hours will increase slightly to assist them in maintaining cleanliness and order of the facility. The administrator will maintain the same hours and functions including organisation and archiving of all records.</p> <p>The laundry is currently undertaken offsite, but SCL are reviewing this and may opt to bring all laundry services back in house in the future.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are electronic.</p> <p>All staff have individual log-in details and access levels are assigned according to role defined guidelines. An external provider manages the database, back-up and security. Individual resident files sampled, demonstrated service integration. Medication charts are completed using a secure electronic management system.</p> <p>Electronic progress notes and care plans are in the electronic database and are legible, dated and identified to the relevant staff member including designation. The electronic systems are password protected.</p> <p>Provisional Audit</p> <p>The director of SCL and acting facility manager stated that there appears to be no historical residents' records, or other business documentation. The current electronic database is problematic. The system (Geras) has been in place for some time and adapted a number of times but still has some limitations. The prospective provider stated they will be reviewing this system within three months of assuming ownership and hope to identify an effective system designed for the aged care sector which can also be linked to the existing call bell</p>

		system.
<p><b>Standard 1.3.1: Entry To Services</b></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>	FA	<p>Woodhaugh has a comprehensive admission policy. Residents are assessed prior to entry to the service by the needs' assessment team. Specific information is available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service and residents and/or family/whānau are provided with associated information such as the Code, how to access advocacy and the health practitioners code. Six of the seven admission agreements sighted aligned with contractual requirements.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</p>
<p><b>Standard 1.3.12: Medicine Management</b></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>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses' complete annual medication competencies and medication education. Medication reconciliation occurs against the robotic rolls for regular medications. There were no standing orders but there is hospital impress stock held. All eye drops were dated on opening. Records of medication reconciliation are entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were no residents self-medicating. The medication fridge temperature is monitored weekly with temperatures within acceptable limits; however, the medication room temperature was not monitored. There is a medication trolley which can be locked, however, on the day of the audit it was observed being left outside of the registered nurse's line of site.</p> <p>Fourteen medication charts on the electronic medication system were</p>



		<p>reviewed. All charts had photo identification and allergy status documented. The effectiveness of 'as required' medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly.</p> <p>Provisional Audit</p> <p>The prospective provider demonstrated knowledge of NZ medicines related legislation and regulations including these standards. They are currently working on site to resolve and remedy the corrective actions previously identified and providing the evidence as specified to SDHB by 16 December 2020.</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>PA Low</p>	<p>The main kitchen is adjacent to one of the dining rooms. There are two cooks and two kitchenhands who have all completed food safety training. Meals are plated and served to residents in the dining room. Meals are transported immediately in hot dishes to the other dining room and served from a trolley to residents. Fridge and freezer and food temperatures are monitored and recorded daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained.</p> <p>There is a four-weekly seasonal menu in place, which was reviewed by a dietitian in 2018 and February 2020. The Food Control plan was verified as part of this audit.</p> <p>The kitchen is informed of resident dietary needs and changes by the registered nurses. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals are provided. There was mixed feedback around the quality of the meals from residents interviewed.</p> <p>Provisional Audit</p> <p>The prospective provider demonstrated a sound knowledge about the nutritional requirements of older people, safe food management and related legislation and regulations including these standards. They are currently working on site to resolve and remedy the corrective actions previously identified which includes providing the evidence as specified to SDHB by 15 January 2021. They stated they have identified a new</p>

		chef who will commence employment shortly. This person's first priority will be to review the menus with input from dieticians and other chefs, implement all recommendations made and make improvements to address residents' concerns.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service has an accepting/declining entry to service policies. The referral agency, potential resident and/or family/whānau would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available or the service cannot provide the assessed level of care.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files reviewed indicated that all appropriate personal needs information was gathered during admission in consultation with the resident and their relative where appropriate. An initial assessment was completed on admission including the services assessments. The outcomes of risk assessments were included in the initial assessment and long-term care plans. The files reviewed had interRAI assessment completed for long-term residents and six monthly re-assessments completed as part of the six-monthly care plan evaluations, however, these were not always completed within timeframes (link 1.3.3.3). Risk assessment tools were reviewed at least six monthly or when there was a change to a resident's health condition.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The long-term care plans are generated within the electronic resident management system, all staff have access to these to update files and complete progress notes. The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement in the care of the resident. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status and either resolved or transferred to the long-term care plan as an ongoing problem.

<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>PA Moderate</p>	<p>Care plans reviewed were goal orientated and met the resident's needs. Residents and relatives interviewed stated their needs are being met. If a resident's condition changes the RN initiates a GP consultation or nurse specialist referral.</p> <p>There were five residents with current wounds (one rest home four hospital). There were no wound assessment, planning, or evaluation forms completed for the five wounds (one laceration, one complex wound, one pressure injury, one hernia and one radiation burn), and two other residents were having areas being dressed with no documented assessment plan or evaluation. Registered nurses can access advice and support from the district nurses and Southern District Health Board (SDHB) wound nurse specialist. Staff reported there was sufficient pressure relieving devices in use and available. There were little dressing supplies available as sighted in the treatment room, however the manager reported the order was due the following week.</p> <p>A good supply of continence products was sighted, and the nurses described having access to the continence and stoma nurses at the SDHB.</p> <p>Monitoring records sighted included weights, vital signs, neurological observations, bowel records, food and fluids, blood sugar levels, pain, repositioning charts, fluid balance and challenging behaviour monitoring charts, resident weights, blood pressure, respiratory rates, pulse.</p> <p>Provisional Audit</p> <p>The prospective provider demonstrated knowledge and understanding about the known safe practice for wound management and timeframes, processes and contractual requirements for service delivery. They are currently working on site to resolve and remedy the corrective actions previously identified and providing the evidence as specified to SDHB by 15 January 2021.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT) 8.30 am - 3.30 pm five days a week to implement the activity programme for rest</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>home and hospital residents.</p> <p>As part of the Covid 19 management plan activities provisions were spilt into two areas. There is a morning and afternoon programme with the activities including but not limited to; exercises, discussions, newspaper reading, quizzes, ball games. Activities meet the cognitive, physical and emotional abilities of the residents. One-on-one activities are provided in resident's rooms for residents who choose not to participate in the group activities. Celebrations and festive occasions are celebrated. Volunteers have stopped coming since Covid 19 and the DT will invite them back in when she is able. The service hires a wheelchair mobility van for residents for outings.</p> <p>The DT completes a resident profile on or soon after admission and takes a social history. The assessment information is used to develop a diversional therapy plan which is evaluated six monthly as part of the interRAI and care plan review/evaluation process. However, not all files reviewed had current assessment and evaluation (link 1.3.3.3).</p> <p>Residents have the opportunity to feedback on the programme through resident meetings and annual surveys. Residents and relatives interviewed were complimentary of the activities offered.</p> <p>Provisional Audit</p> <p>The prospective provider has identified in their transitional plan and discussed via interview, the need to employ an additional full-time activities staff member to meet the recreational and social needs of all residents. They also intend to purchase a van as soon as possible to provide outings for residents. They reported that it appears that residents have not had any external outings for some time.</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>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. There is a written evaluation against the resident goals that identifies if the goals have been met or unmet. Long-term care plans are updated with any changes to meet the resident goals, however, not all long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health (link 1.3.3.3). Short-term care plans were evident for the care and treatment of short-</p>

		term problems for residents and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager and RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the need's assessment team for reassessment of a resident level of care from respite to rest home and for rest home to hospital level of care.
<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	The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals were secured in designated locked cupboards including an outside locked room. Chemicals were labelled, and safety datasheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided by Ecolab. A waste management internal audit was last completed March 2020. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective equipment/clothing (PPE) while carrying out their duties. There are distinguished areas identified for donning and doffing PPE if required. There are plentiful supplies of PPE and hand sanitiser.
<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>	PA Low	The facility has a current building warrant of fitness that expires on 18 February 2021. There is a maintenance person four days a week who reports to the facility owner/manager. The planned maintenance programme has been completed to date, including electrical testing and tagging of electrical equipment, calibration and testing of clinical equipment, monthly call bell audits and monthly hot water temperatures. There have been occasions when the hot water temperatures in resident areas are outside the 45 degrees requirements, corrective actions have been put in place. Essential contractors are available 24-

	<p>hours.</p> <p>The physical environment allows easy access/movement for the residents and promotes independence for residents with mobility aids. There is ramp access to the outdoors with landscaped gardens and raised garden beds. There is outdoor seating and shade provided.</p> <p>The refurbishment of the upstairs Gables wing has been completed. The rooms are all single with mobility toilets and shower facilities. There is an open plan lounge and dining area. There are call bells in each resident room, however, there was no call bell in the living areas. The lift to access this floor is tested as part of the building warrant of fitness. This area is not yet occupied.</p> <p>The registered nurses and caregivers interviewed stated they have all the equipment required to deliver safe resident care.</p> <p>Provisional Audit</p> <p>Telephone interview and review of documents submitted confirmed that SCL have no short-term plans to change the building foot print. The directors are knowledgeable about NZ building requirements including essential emergency and security systems and what constitutes an appropriate, accessible and fit for purpose environment for older frail persons. They described the new upstairs area as unsuitable for hospital level care residents and are considering other ways it could be used. There are eight bedrooms upstairs which have been approved for dual purpose use (hospital/rest home) but there is no way to safely and comfortably transport a hospital resident or a deceased person in the lift. Plus, there is no easy or ready access to the outside. There would also need to be an additional RN allocated to that area because of its distance and proximity from the rest of the service delivery areas. There are another seven bedrooms upstairs which are currently being rented by staff. The documented business plan and 'SWOT' analysis considers the possibility of using the space for training purposes or renting out all of the rooms.</p> <p>Other documented considerations are adding dementia care services, building a café and acquiring a contract to provide a community day activities programme on site.</p> <p>The prospective provider expressed concerns that some of the internal</p>
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		<p>doors within the facility do not meet the fire regulations. These are not standard fire doors, they are heavy and considered by the directors to not be safe or suitable for older people, and do not automatically close if the fire suppression system is activated. They are currently seeking input from their emergency services supplier and Fire and Emergency Services New Zealand (FENZ) to confirm that an approved evacuation scheme is in place. There have been modifications made to the internal areas which included adding new walls that blocked egress. It is not known if the evacuation scheme was reviewed at that time and/or when the upstairs area was refurbished.</p> <p>The director stated they have commenced recruitment to employ a full-time maintenance person, as none are currently employed or appear to have ever been employed.</p> <p>Other documented and expressed plans are to immediately purchase a van for residents' outings. The director said that it appears residents have not been provided opportunities for outings this year. This is further discussed in standard 1.3.7.</p> <p>The previous corrective action about there being no call bells in living areas upstairs was being progressed but this will now depend on what is determined as suitable use of that area.</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 communal toilets located close to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff are undertaking personal cares.</p> <p>There are two of three communal showers and one of five toilets in north wing which are large enough for usage of mobility equipment. Some rooms have ensuite toilets. There are a number of mobility bathrooms and toilets in north wing. There is a mobility shower/toilet on level one that has been fully renovated. Currently level one has no residents.</p> <p>There are four mobility bathrooms and other toilets available in south wing.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All residents' rooms are of an appropriate size to allow care to be provided. There are dedicated dual-purpose rooms which allow for safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms, and this has occurred.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The facility has a large lounge/dining area in south wing, another smaller lounge down one wing and a lounge area upstairs. There are two lounges in north wing, one is a combined dining and lounge area. The lounges allow for individual or group activities.</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 Low</p>	<p>There are policies/procedures and audits of the cleaning and laundry service. Procedures have been updated in relation to outbreak management. All linen and personal clothing is laundered off-site and collected six days per week. There is a locked disused laundry, which is used to store chemicals along with clothing and linen awaiting pickup for laundering. Clean laundry is returned three days a week and stored in a sorting room. There are dedicated cleaning staff on duty each weekday and caregivers also complete cleaning tasks. Cleaning hours have increased and a cleaning schedule developed including 'deep cleaning'. The service has addressed the corrective actions from the DHB Covid preparedness assessment around cleaning, however, there was a lingering odour noted throughout the audit in the south wing, this was being investigated at the time of the audit.</p> <p>The laundry service audit was carried out in August 2020. Cleaning audit was completed in April 2020 and included an implemented corrective action.</p> <p>Provisional Audit</p> <p>As reported elsewhere the prospective provider intends to increase the number of hours allocated for cleaning each day by an additional 1.5 hours per cleaner. The laundry is currently undertaken offsite, but SCL are reviewing this and may opt to bring all laundry services back in house in the future.</p> <p>The prospective provider is progressing the corrective action by</p>



		monitoring the extent of cleaning and preparing to submit all the evidence required by the DHB by 15 January 2021
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six monthly fire evacuation drills take place (last held May 2020). There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are emergency folders with specific information held in each nurses' station and civil defence supplies in back packs. All supplies including food stores are checked monthly. There are adequate supplies in the event of a civil defence emergency including a water tank. Emergency management is included in staff orientation and ongoing as part of the education plan. A minimum of one person trained in first aid is available at all times.</p> <p>There are call bells in the residents' rooms and ensuite, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The building is secure after hours.</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>	FA	Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
<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>	PA Low	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the infection control coordinator and is supported by the clinical manager. There is an IC job description that outlines the responsibility of the role. The infection control coordinator is responsible for the collation of infection events and reporting to the combined infection control team/H&amp;S meeting and also to the monthly staff meeting. The 2019 infection control programme has been reviewed and identifies an increase in infections from 2018.</p> <p>The facility has access to professional advice and has developed close links with the GPs, community laboratory, the public health department</p>

		<p>and the local district health board (DHB).</p> <p>There have been no outbreaks since the last audit. Sufficient supplies of provisions to manage infection control including liquid soap in all rooms and plentiful supplies of hand gel were sighted. The IC team have worked with the DHB to develop comprehensive Covid 19 policy and procedures and an outbreak management plan. Screening of all visitors is in place. A staff contingency plan has been developed for red zone in the upstairs unit. There were eight corrective actions identified at the DHB Covid-19 assessment audit. These have been addressed.</p> <p>Provisional Audit</p> <p>The prospective provider demonstrated a sound knowledge of current infection control practices, related legislation and regulations including these standards. The directors of SCL who are the current facility manager and CSM, are progressing the corrective actions in readiness to submit the evidence required to SDHB by 15 January 2021.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has been in the role for the last year. She is supported by the clinical manager. The IC coordinator and clinical manager described their focus around Covid and outbreak management procedures. The IC coordinator is a member of NZNO IPC and attended an update in 2019. Management have committed to rostered IC hours dedicated to IPC and facilitation of IPC professional development.</p> <p>The infection control coordinator has access to GPs, laboratory service, the infection control nurse specialist and public health departments.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including 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. The policies are developed and reviewed in consultation with an external infection control consultant. Covid 19 policy and procedures and</p>

type of service provided.		outbreak management plan has been developed and includes all processes at Woodhaugh.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and annually. Infection control is discussed at handovers with care staff. Healthcare assistants interviewed could describe standard precautions for the prevention of infection. Covid outbreak training was completed March 2020.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection control data is discussed at monthly staff meetings but not in the combined H&amp;S/IC committee (link 3.1.1). There is little documented evidence of analysis of infections, identification of trends and consequent corrective actions (link 3.1.1). Internal audits for infection control are included in the annual audit schedule.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Woodhaugh has adopted a restraint free policy since August 2019. Interviews with the staff confirmed their understanding of restraints and enablers. On the day of audit, there were no residents with restraint and no residents using enablers. Restraint education was last held in August 2020.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality data is discussed at meetings, staff can describe the information discussed as per the minutes. However, the data is not analysed for trends. There is evidence of discussion around Covid 19, however, there is no evidence of discussion around infection control in meeting minutes (link 3.1.1). Staff reported corrective actions and improvements are discussed at meetings, however there is no evident follow up of these discussions.</p>	<p>(i) No evidence of analysis and trending of quality data.</p> <p>(ii) Staff and residents report no follow up actions form corrective actions as discussed in meetings.</p>	<p>(i) Ensure analysis and trending of quality data is documented.</p> <p>(ii). Ensure corrective actions discussed at meetings are followed through and progress towards achievement is discussed at previous meetings are documented is discussed and followed through in meeting minutes.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to</p>	PA Moderate	<p>All staff administering medications have current competencies in place. There were no expired medications</p>	<p>(i) No monitoring of the medication room temperature.</p> <p>(ii) The registered nurse was</p>	<p>(i) Implement monitoring of the treatment room to ensure the temperature</p>

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		on site, the medication trolley is lockable, and however the medication round sighted was not in line with current legislation and requirements. The medication fridge temperatures are checked, recorded regularly, and are within ranges, however the temperatures of the medication room had not been checked or recorded.	observed not keeping the medication trolley within their line of site.	does not exceed more than 25 degrees.  (ii) Ensure all registered nurses receive education regarding the security of the medication trolley.  60 days
Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	The manager stated they have been making improvements to the food service. A dietitian was contracted to complete a review of the food service in February 2020. Areas for improvement were identified including (but not limited to); having a list of residents on 'High Energy High Protein' diet needs present in the kitchen as per dietitian clinical notes. Nine residents interviewed had variable feedback on the food service. There was noted negative feedback in the resident meetings, but outcomes or corrective actions were not documented therefore it was difficult to determine whether these issues were addressed.	There was noted negative feedback in the resident meetings, but outcomes or corrective actions were not documented therefore it was difficult to determine whether these issues were addressed. Three rest home and two hospital residents were overall not satisfied with the meal services. One rest home resident and one hospital resident stated the meals were cold at times. Two rest home residents and two staff reported on occasions they run out of food at teatime and toast is provided in the place. There are no incident forms documented to identify the times when they run out of the teatime meal.	Ensure resident concerns around the meals are addressed and clearly documented. Ensure any incidents of meal shortage is documented through the quality and corrective actions established.  90 days
Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided	PA Low	There are policies and procedures in place around care planning and timeliness of assessments and care planning. The files reviewed had initial assessments and long-term	i) Three of the seven files (two hospital and one rest home) did not have initial facility-based assessments, interRAI assessments, long-term care plans,	Ensure all assessments, care planning and evaluation timeframes meet expected timeframes in line with policy.

<p>within time frames that safely meet the needs of the consumer.</p>		<p>care plans, interRAI assessments, and evaluations documented, however, these were not always in line with policy, and not all files had a current assessment and evaluation in place.</p> <p>Timelines and frequency of assessments, planning and evaluation for nursing care plans and activities care plans were not in line with policy and required timeframes. Four files reviewed demonstrated that the required timeframes had been met. Two of the hospital resident files did not have a current activities assessment and evaluation</p> <p>There are policies and procedures in place around care planning and timeliness of assessments and care planning. The files reviewed had initial assessments and long-term care plans, interRAI assessments, and evaluations documented, however, these were not always in line with policy, and not all files had a current assessment and evaluation in place.</p> <p>Timelines and frequency of assessments, planning and evaluation for nursing care plans and activities care plans were not in line with policy and required timeframes. Four files reviewed demonstrated that the required timeframes had been met. Two of the hospital resident files did not</p>	<p>and evaluations, completed within the required timeframes.</p> <p>ii) Two of the hospital resident files did not have a current activities assessment and evaluation.</p> <p>i) Three of the seven files (two hospital and one rest home) did not have initial facility-based assessments, interRAI assessments, long-term care plans, and evaluations, completed within the required timeframes.</p> <p>ii) Two of the hospital resident files did not have a current activities assessment and evaluation.</p>	<p>60 days</p>
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		have a current activities assessment and evaluation		
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There were five residents with current wounds. Registered nurses can access advice and support from the district nurses and Southern District Health Board wound nurse specialist, however, there were no wound assessment and management charts used. All progress regarding assessment, progress and change of dressings are recorded in the progress notes, which was difficult to evaluate whether the wound was progressing or deteriorating. There were little dressing supplies available as sighted in the treatment room, however the manager reported the order was due the following week.</p>	<p>(i) There was no wound assessment used to evidence progression or deterioration of the wound bed.</p> <p>(ii) There was no wound management planning used to guide staff for use of dressings, or frequency of changes</p> <p>(iii) There was no corresponding evidence of wound progression or deterioration.</p> <p>(iv) There was not an adequate wound dressing supplies sighted in the treatment room.</p>	<p>(i)-(iii) Utilise an assessment, management and evaluation process with all wounds. (iv) Ensure there is adequate and appropriate supplies of wound dressings.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The Gables (upstairs wing) refurbishment has been completed. The resident rooms are of adequate size and all have external windows and heaters which can be adjusted individually. There is lift access to the upstairs wing. Call bells are installed in each resident room and toilet/shower facilities, however, there is no call bell available in the living areas.</p>	<p>There was no call bell installed in the living areas of the Gables (upstairs) wing.</p>	<p>Ensure call bells are installed in the living areas of the Gables wing before residents are residing in this area.</p> <p>Prior to occupancy 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 Low</p>	<p>The housekeeping staff interviewed were knowledgeable around the chemicals used and schedules in place. Extra housekeeping hours have been allocated. The facility was noted to be clean during the audit, however, there was an odour present in the south wing. This had been identified and cleaning staff were investigating this.</p>	<p>Unpleasant odours were noted in the south wing during the audit.</p>	<p>Ensure unpleasant odours are managed.</p> <p>90 days</p>
<p>Criterion 3.1.1</p> <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.</p>	<p>PA Low</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the infection control coordinator and is supported by the clinical manager. There has been an increased focus on developing the comprehensive Covid 19 policy and procedures and an outbreak management plan. The IC coordinator was unclear who the IC team is. The policy describes a combined H&amp;S/IC meeting. A review of the meeting minutes for 2020 did not identify a discussion of IC stats or analysis. Infections are discussed in the staff meeting, however, infections identified are not separated into areas or rest home/hospital. There is no identified analysis or benchmarking.</p>	<p>i) The IC coordinator was unclear who the IC team is.</p> <p>ii) The policy describes a combined H&amp;S/IC meeting. A review of the meeting minutes for 2020 did not identify a discussion of IC stats or analysis. Infections identified are not separated into areas or rest home/hospital.</p> <p>iii) There is no identified analysis/trends or benchmarking.</p>	<p>i) Ensure the role of the IC team/committee is clear.</p> <p>ii) Ensure infection control stats are discussed at the meeting.</p> <p>iii) Ensure stats are analysed, trends identified and corrective actions established where possible and addressed through meetings.</p> <p>90 days</p>



## 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.

No data to display
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End of the report.