

CSR Healthcare Limited - Remuera Rest Home and Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	CSR Healthcare Limited
Premises audited:	Remuera Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 October 2020 End date: 21 October 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:	33

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

Remuera Rest Home and Hospital provides rest home and hospital (geriatric and medical) levels of care for up to 35 residents. On the day of the audit there were 33 residents.

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

The facility manager is a registered nurse. He is appropriately qualified and experienced and is supported by a team of experienced staff. Feedback from residents and families was very positive about the care and services provided.

This certification audit identified that improvements are required in relation to the business plan and corrective actions. The service has achieved a continuous improvement around good practice.

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>All standards applicable to this service fully attained with some standards exceeded.</p>
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Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Cultural values and beliefs are understood and respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community.

Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Business goals are documented for the service. The risk management programme includes a risk management plan, incident and accident reporting, and health and safety processes. Quality systems include regular monitoring of quality and risk data and an internal auditing programme.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The facility manager is a registered nurse (RN) who is on site five days a week and is on call when not on site. He is supported by a team of RNs, including two designated clinical leaders. 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

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioner and visiting allied health professionals.

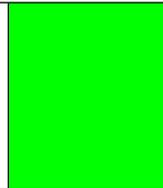
Registered nurses and medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The recreation officer implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

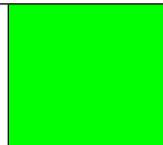
Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All but one of the residents' rooms are single occupancy. Twenty-two rooms have ensuites, one room has a toilet and hand basin and the rest have hand basins only. There are adequate numbers of toilets and showers.

External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system.

Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. Seven residents were using a restraint at the time of the audit and two residents were using an enabler. The facility also has environmental restraint in place with appropriate measures undertaken to ensure it is safe and administered appropriately.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. Appropriate measures are in place for Covid-19.

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	1	47	0	2	0	0	0
Criteria	1	98	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. The facility manager/registered nurse (RN) and ten staff interviewed (three RNs including two clinical leaders, four healthcare assistants (HCAs), one cook, one cleaner, one recreational officer) could describe how the Code is incorporated into their job role and responsibilities. Staff receive training on the Code during their induction to the service. This training continues via the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident in all six resident files reviewed: two rest home (one YPD, one long term support-chronic health condition (LTS-CHC)); and four hospital including one YPD and one LTS-CHC. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal cares. Advanced directive and enduring power of attorney (EPOA) evidence is filed in the residents' charts.</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>	FA	<p>HDC advocacy details are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p> <p>Community links are established with local community groups. Residents who are able are supported to come and go from the facility as they please. They regularly visit the local cafes and shops and attend community activities.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>A record of complaints received is maintained by the facility manager. Three complaints have been lodged in 2020 (year-to-date) and were reviewed. Complaints are being managed in accordance with HDC guidelines. One anonymous complaint was lodged with the DHB in May 2020. An action plan was developed, which addressed details relating to this complaint. Staff were kept informed, evidenced in the staff meeting minutes. This complaint has been signed off by the DHB as resolved (30 September 2020). The other two complaints reviewed were also signed off as resolved.</p> <p>Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly.</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 and the HDC advocacy service are included in the resident information that is provided to new residents and their families. The facility manager or clinical leader discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the three-monthly residents' meetings. Interviews with six residents (four hospital including two young persons with a disability [YPD] and two rest home including one YPD) and four family (one rest home, three hospital</p>

		including one YPD) reported that the residents' rights were being upheld by the service.
<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>The residents' personal belongings are used to decorate their rooms. The HCAs interviewed (including those who work both the AM and PM shifts) reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. One resident who is unable to speak has a sign on their door to please knock before entering.</p> <p>HCAs reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Shared toilets include appropriate door locking mechanisms.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive regular education and training on abuse and neglect, which begins during their induction to the service.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Māori health policy is documented for the service. Links are established with a kaumātua from the Greenlane Clinical Centre. Rooms are blessed following the death of a resident. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.</p> <p>A comprehensive Māori health plan is in place for residents who identify as Māori. Cultural considerations and interventions are identified around the domains of resident cares, communication, restraint, challenging behaviours, food, and spirituality. There were no Māori residents living at the facility at the time of the audit.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as an annual training topic.</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 desires from the time of admission. A cultural needs assessment is completed as part of the admission process. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline.</p> <p>Beliefs and values are incorporated into the residents' care plans, evidenced in all six care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. One family interviewed was related to a resident who was unable to speak English. Phone translation applications are used to assist with translation when the family member is unavailable. The care staff reported that they are also able to</p>

		communicate with the resident using non-verbal communication. The family member reported that the resident is very happy with the services being provided.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the HCAs role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The facility manager is a registered nurse who is on site five days a week and is supported by a team of RNs, including two clinical leaders. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Resident meetings are held three-monthly. Residents and family/whānau interviewed reported that they are satisfied or very satisfied with the services received. This was also confirmed in the April 2020 resident/family satisfaction survey whereby 97.83% of residents and families (sample of 23) were very satisfied with the services received.</p> <p>The service receives support from the district health board (DHB). Physiotherapy services are provided as needed. A van is available for regular outings. A podiatrist visits the facility every six weeks. Mental health services through the DHB are available on request.</p> <p>The environment allows for close relationships between the staff and residents. A recreational officer is on site five days a week which is an increase of one day compared to the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. There were two residents at the facility who were unable to speak or understand English. Families and staff are utilised</p>

		in the first instance. Phone translation applications have also proved to be successful.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Low	<p>Remuera Rest Home and Hospital provides rest home and hospital levels of care for up to 35 residents. Fifteen rooms are designated for rest home level of care and twenty rooms are designated as dual-purpose (hospital/rest home). On the day of the audit there were 33 residents (14 rest home and 19 hospital). This included six residents on the LTS-CHC contract (two rest home and four hospital), and four residents on a YPD contract (two rest home and two hospital). The remaining residents were on the aged residential care services agreement contract (ARRC).</p> <p>A philosophy, mission, vision and values are in place. The business plan (2019 – 2020) is established with six key result areas identified (finance, operations, facilities, business development, quality improvement, personnel development). There was a lack of evidence to indicate that the business plan (and quality/risk plans) are regularly reviewed.</p> <p>The facility manager is an RN who has been in his role for six years and has eleven years of management experience in the aged care sector. He maintains a minimum of eight hours of professional development per year relating to the management of an aged care facility.</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>A delegation of authority policy is being implemented. There are two clinical leaders/RNs who are responsible for clinical operations in the absence of the facility manager. The owner would assume administrative responsibilities in the absence of the facility manager.</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</p>	PA Low	<p>A quality and risk management system is established (link 1.2.1.1). Policies and procedures align with current good practice. Policies have been reviewed, modified (where appropriate) and implemented. Reviews take place a minimum of two yearly or when changes occur (if sooner). A document review schedule is in place. New policies are discussed with staff as a regular agenda item in staff meeting minutes. Staff are asked to sign that they have read new/revised policies.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety</p>

<p>that reflects continuous quality improvement principles.</p>		<p>reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, falls [witnessed and unwitnessed], infections, challenging behaviours) and is collated and analysed. An internal audit programme is being implemented. A selection of corrective actions developed for areas identified for improvements were not monitored to indicate that these corrective actions were resolved. Staff are informed of quality results via staff meetings, handovers and daily discussions.</p> <p>The facility manager is the health and safety officer. He is supported by a health and safety committee. Staff health and safety training begins during their induction to the service and includes a self-learning/competency package. Health and safety is a regular topic covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. New contractors are orientated to health and safety processes.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, intentional rounding and challenging behaviour plans. Falls have reduced over the past year with one resident identified as a frequent faller.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme.</p> <p>Fifteen accident/incident forms were reviewed (seven unwitnessed falls, five witnessed falls, one challenging behaviour, two skin tears with bruising). Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurologic observations are conducted for suspected head injuries and unwitnessed falls.</p> <p>The facility manager is aware of statutory responsibilities in regard to essential notification with examples provided of notification reports completed since the previous audit (eg, pressure injuries grade three or higher, one outbreak).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (three HCAs, two staff RNs, one clinical leader/RN) included evidence of the recruitment and induction process, including reference checking, signed employment contracts, job descriptions and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice that is specific to the position. Staff interviewed stated that new staff were adequately orientated to the service.</p>

<p>practice and meet the requirements of legislation.</p>		<p>An education and training programme is provided for staff that meets contractual obligations. In-service training is linked to staff meetings with attendance consistently above 80%. Competencies are completed specific to worker type and include (but are not limited to) health and safety, medication, manual handling, food handling, restraint minimisation. A register of current practising certificates for health professionals is maintained. Three out of six RNs have completed their interRAI training. A first aid trained staff member is always available 24/7, including on outings.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy aligns with contractual requirements. The facility manager is on site five days a week and is on-call when not available on site 24/7.</p> <p>There are two clinical leaders/RNs. One clinical leader is on site Monday – Friday (AM shift) and the second clinical leader is on site Monday – Wednesday (AM shift) which includes during doctor rounds. Staffing is flexible to meet the acuity and needs of the residents. The AM shift is staffed with two staff RNs, the PM has one RN and the night shift has one RN.</p> <p>There are adequate numbers of HCAs available with staff extending their hours where needed. Three HCAs are rostered on the AM shift, seven days a week (three long shifts and one short shift) and three HCAs are rostered during the PM shift (two long shift and one short shift). Two HCAs cover the night shift.</p> <p>No agency staff is being used, although during the Covid-19 lockdown agency staffing was necessary.</p> <p>A recreational officer is rostered five days a week for six hours a day. HCAs are responsible for laundry duties. A separate cleaner is employed five days a week for six hours a day.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory.</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 residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed and signed by the relevant HCA or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses a paper-based and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications to hospital residents. Medication competent HCAs can administer medications to rest home residents. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication room and fridge temperatures are checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the medication signing form. Twelve medication charts were reviewed (eight hospital and four rest home). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</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</p>	<p>FA</p>	<p>The service has one cook who covers Monday to Sunday and one weekend cook. Both cooks have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from the kitchen. Meals going to residents' rooms on trays have plate covers to keep the food warm. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to</p>

<p>service delivery.</p>		<p>monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes/dislikes were noted. The four weekly menu cycle is approved by a dietitian. The residents choose from two options. All resident/families interviewed were satisfied with the meals.</p> <p>The food control plan is valid until November 2020. The facility has just been re-audited, and the food control plan was re-validated but the certificate has not yet arrived.</p> <p>Food, fluid and nutritional needs of residents are provided according to nutritional guidelines. Referrals are made to a dietitian as required. Annual food satisfaction surveys are completed. Residents may discuss any dietary problems with the cook and at residents' meetings.</p> <p>Since 2017 there has been a steady rise in food satisfaction (2017- 89.9%, 2018 - 91%, 2019 - 95%). The latest food satisfaction survey in 2020 showed an increase to 99.56%. Residents stated that they would like more choice so at the main meal they now have a choice of two options. All residents/families interviewed were satisfied with the meals and stated that the choice of two options at the main meal has made a difference.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but were not limited to) nutrition, continence, pain, falls risk and pressure injury risk.</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>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions are documented to support needs and provide detail to guide care. The facility has some residents with complex needs and the care plans reflected this. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people. All interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and families interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there an unwitnessed fall or residents hit their head.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>The facility has reviewed their wound management policies and procedures. Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently three wounds being treated – one chronic ulcer and two minor skin tears. The number of wounds has been reducing over the past year. Advice is sought from the wound care nurse specialist as required. There are currently no pressure injuries. Pressure relieving equipment is in use. All residents have a pressure injury risk assessment on admission, six monthly thereafter or as required. There has been education for all staff on wound management and pressure injury prevention.</p> <p>Staff have also completed education around managing challenging behaviour. Care plans have clear guidelines and strategies for any residents exhibiting challenging behaviours. Behaviour monitoring charts are available and in use.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for</p>	<p>FA</p>	<p>There is one recreation officer who works six hours Monday to Friday. On the days of audit residents were observed listening to a newspaper reading, playing bingo, playing balloon tennis, coming back from Communicare and going for walks outside.</p> <p>There is a weekly programme in large print on the noticeboard in the main lounge and each resident is given</p>

<p>a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>a copy of the weekly programme to keep in their room. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is Roman Catholic communion every Monday and some residents go out to church at the weekend.</p> <p>There are van outings twice weekly. One of the outings is to go shopping and the other is to the library. When the weather is good, they also have trips to the park and beach. The van driver has a first aid certificate. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. There is entertainment fortnightly.</p> <p>One resident has her own dog and there is monthly pet therapy (postponed over Covid-19).</p> <p>There is community input from the local preschools and choirs. Residents go out shopping, to the library, to Communicare and one to the Blind Foundation.</p> <p>YPD residents who are sufficiently able go out shopping for coffees and to MacDonalDs. They are also able to access up to date DVDs.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held three-monthly.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Except for the new admissions, all plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health</p>

<p>External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>services for older people, the physiotherapist and the speech language therapist. Discussions with the RN identified that the service has access to a wide range of support including the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 25 June 2021. There is no maintenance person, but the facility manager coordinates the maintenance process. There is a preventative and reactive maintenance schedule. Contracted plumbers and electricians are available when required. The cleaner works as the gardener on Saturdays.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. There are fourteen bedrooms carpeted but the rest have vinyl. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Twenty-two rooms have ensuites. One room has a hand basin and toilet. All other rooms have hand basins only. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors.</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>There is one shared room and all others are single. The shared room has privacy curtains. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<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>There are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining room is spacious.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic</p>	<p>FA</p>	<p>All laundry is done on site. The HCAs do the laundry. The laundry is small but adequate. It is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and manufacturing safety data sheets (MSDS) available. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All</p>

<p>cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>chemicals on the cleaner's trolley were labelled. There is a sluice room which is used for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept locked when not in use.</p>
<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>	<p>FA</p>	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum) with the last fire drill taking place on 28 May 2020. There is a New Zealand Fire Service approved evacuation scheme.</p> <p>The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas cooker is available on the premises.</p> <p>The call bell system was recently upgraded. Four attenuating panels are accompanied by an alarm. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked monthly.</p> <p>There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. All staff are required to complete their first aid training.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. There are panel heaters in resident's rooms and heat pumps in communal areas. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free. Residents have been offered smoking cessation programmes.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which</p>	<p>FA</p>	<p>There are clear policies and procedures for infection, prevention and control which minimises any risk of infection to residents, staff and visitors. Infection control management is appropriate to the size and scope of the facility.</p> <p>There is an infection control (IC) coordinator (a RN clinical lead) who is responsible for infection control. The</p>

<p>minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>coordinator liaises with and reports to the facility manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the facility manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There are ample supplies of personal protective equipment (PPE). Residents are offered the annual influenza vaccine.</p> <p>In April 2020 there was a probable case of a staff member with Covid-19. This was ably managed by the facility with the assistance of the DHB. The staff member tested negative.</p> <p>Due to Covid-19 all visitors to the facility sign in and have their temperatures checked. During lockdown residents were able to keep in contact with friends/family by zoom. At the outbreak of Covid-19, the facility manager put together a folder with a snapshot of each resident in case residents had to be nursed by staff from agencies or other facilities.</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>	<p>FA</p>	<p>The IC coordinator is an experienced RN. She has access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</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</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by the facility manager.</p>

organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<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	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year with particular emphasis on hand hygiene and donning and doffing of PPE due to Covid-19. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
<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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified and analysed, and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. Seven (hospital level) residents were using a restraint (bedrails, one lap belt) and two (hospital level) residents were using an enabler (bedrails). The facility has environmental restraint in place, which affects 21 residents. The entrance door is kept locked with the code to exit placed in a visible location. Written consent has been obtained for those (21) residents who are unable to freely exit the facility.</p> <p>Staff receive training on restraint minimisation, which includes testing their competency. The healthcare assistants interviewed were able to describe the difference between an enabler and a restraint.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes</p>	FA	A restraint approval process is in place. Restraint minimisation policies and procedures describe approved restraints including environmental restraint. An RN is the designated restraint coordinator. She is knowledgeable regarding this role.

(including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is being implemented.</p> <p>Two residents' files where restraint was being used were reviewed. Each residents' file included a restraint assessment, which included the identification of any risks associated with the use of the restraint. Restraint use was linked to the residents' care plans.</p> <p>Four files were sighted for residents that are environmentally restrained, which included identification of the risks of the environmental restraint within the assessment.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>A restraint register is in place. The register identifies any residents using a restraint or enabler, and the type of restraint used (including environmental restraint). The restraint assessment reviewed identified that restraint is being used only as a last resort.</p> <p>The frequency of monitoring residents while on restraint (other than environmental restraint where this is not indicated), is documented. Monitoring forms are completed when the restraint is put on and when it is taken off. There have been no adverse events reported as a result of restraint use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Restraint use is reviewed six-monthly by the restraint coordinator, meeting requirements of the standard. Restraint use is discussed in the relevant staff meetings.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality	FA	<p>The restraint programme, including reviewing policies and procedures and staff education, is evaluated as evidenced in the document control for restraint policies and procedures, in the meeting minutes and in discussions with the facility manager and restraint coordinator.</p>

review of their use of restraint.		
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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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	A comprehensive business plan is in place but is not regularly reviewed.	The business and quality/risk plans are updated on an annual basis but are not reviewed regularly throughout the year.	<p>Ensure that the business plan and quality/risk plans are regularly reviewed.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet</p>	PA Low	Corrective actions are documented for areas identified for improvements but are not consistently evaluated to indicate if the	Three corrective actions arising from the 2020 internal audit programme (continence promotion and management, medication administration, resident satisfaction) failed to reflect either monitoring or evaluation of the corrective action, or evidence that the	Ensure corrective actions are evaluated with

the specified Standard or requirements is developed and implemented.		corrective action had been effective.	corrective action had been resolved.	documented evidence of resolution. 90 days
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	The service implemented a project around reducing wounds.	<p>The facility had been concerned at the high number of wound/skin conditions for the size of their facility – 53 in 2019. After discussion the following was initiated.</p> <ol style="list-style-type: none"> 1. Improvement of staff knowledge and skills with particular emphasis on prompt reporting and the utilisation of appropriate dressings; 2. Liaison with a wound care specialist to ensure that staff are provided with clinical support and guidance; 3. Monitoring the resident’s dietary needs and providing supplements/extra protein. Referrals made to the dietitian as required; 4. Monitoring the residents fluid intake; 5. Ensuring there are adequate supplies of PPE and dressings; 6. Education for HCAs around the importance of drying skin

			folds well; In 2020 wound/skin conditions totalled 23. This is a reduction of 30
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End of the report.