# Benhaven Care Limited - Camellia Resthome

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Benhaven Care Limited

**Premises audited:** Camellia Resthome

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 30 November 2020 End date: 1 December 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:** 30

# 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 |
|  | 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 |
|  | 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

Camellia Rest Home provides rest home level care for up to 30 residents. On the days of audit there were 30 residents. The service is managed by a facility manager who is supported by one of the directors and staff.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the nurse practitioner.

There is an implemented quality and risk management programme.

The residents and relatives interviewed spoke positively about the care and support provided and close involvement with the community.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Camellia Rest Home practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided, and individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and on-going involvement with community activity is supported. Complaints processes are implemented, and complaints and concerns are managed and documented.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The board of directors have a strategic business plan and annual quality goals with quality objectives. Quality information is reported to monthly staff and management meetings. Since taking over the service in February 2020 the new management has focussed on a number of areas to improve outcomes and service delivery for the residents (meal service, communication with residents/ relatives and staff orientation and education are three areas). Staff interviewed confirmed they are kept informed on risk management matters and outcomes of internal audits. The service has comprehensive policies/procedures to provide rest home level care. There is an orientation programme in place and an annual education programme in place that includes compulsory training for aged care staff. There are documented job descriptions for all positions, which detail each position’s responsibilities, accountabilities and authorities. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery.

## 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. |

There is an admission booklet available prior to or on entry to the service. A registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted nurse practitioner (NP) or general practitioners (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Medication competent health care assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the NP or GP.

The activities assistants implement 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 rooms are single, some have an ensuite. 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. There were no residents using enablers and no restraint use on the day of audit.

## 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. There have been no outbreaks. There is clear information for staff around Covid19 and ample supplies of personal protective equipment.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Camellia Rest Home practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and posters of the Code are displayed at the front entrance. The policy relating to the Code is implemented and staff interviewed (facility manager/registered nurse),five caregivers, two activities coordinators, one cook, one laundry person and one cleaner) 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 and training. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (six rest home). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents’ charts. Two of the six files sampled had advanced directives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry and they are available at the front entrance. Advocacy pamphlets are also displayed in the front entrance along with contacts and numbers. Caregivers interviewed are aware of the resident’s right to advocacy services and how to access the information(in service education by an advocate had recently been undertaken). Interviews with residents and relatives confirmed that they are aware of their right to access advocacy. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service maintains key linkages with other community organisations. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Families interviewed state they are always made to feel most welcome when they visit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. There are complaints forms available. Information about complaints is provided on admission and is readily available in the facility. Interviews with residents and relatives demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint register. Verbal and written complaints are documented. There have been five documented complaints since February 2020. All complaint documentation was reviewed. All complaints had noted investigation, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents and relatives confirmed that any issues are addressed, and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is available in the facility. The facility manager discusses aspects of the Code with residents and their family on admission. Six residents interviewed and five relatives reported that the residents’ rights are being upheld by the service. Residents and family members interviewed state they received sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify 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. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | 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. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Māori consultation is available through the visiting local Iwi and the WDHB cultural advisor for the service. Staff receive education on cultural awareness during their induction and at least two yearly. All carers interviewed were aware of the importance of whānau in the delivery of care for Māori residents (there are two Maori staff). There was one resident who identified as Maori on the day of audit. The resident had a care plan that reflected their culture. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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. 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. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with five caregivers could describe how they build a supportive relationship with each resident. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The directors and management are committed to providing services of a high standard, based on the service philosophy of care. Staff were observed during the days of audit demonstrating a very caring attitude to the residents. Residents interviewed state they are very happy with the level of care provided. The service has implemented policies and procedures that are used at their sister site. The policies and procedures meet legislative requirements. Staff receive a verbal and written handover between every shift that details any significant events. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry and any items they have to pay for that is not covered by the agreement.  The information pack is available and advised that this can be read to residents. Interpreter services are available as required. Relatives interviewed, stated that they are now well informed when their family member’s health status changes and feel comfortable to contact the facility manager for further information/discussion. Discussions with caregivers identified their knowledge around open disclosure. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Camellia Rest Home is a 30-bed facility that provides rest home level care. Occupancy on the day of audit was 30 residents. All residents were under the aged related residential care contract (ARRC). There were no residents under respite care. The home has a day care contract. Two clients attend twice a week.  Camellia Rest Home is privately owned and governed by directors. The directors employ a facility manager to operate Camellia Rest Home. The facility manager (clinical) has been in the role seven months and has experience in the aged care sector, the (DHB) and as an interRAI trainer. She is supported by one of the directors who works on site fortnightly for four days (the director has a good understanding of quality systems and the aged care sector).  The facility manager reports directly to the directors. There is a site-specific strategic business plan that contains the vision, mission and values for Camellia Rest Home. The service has annual quality goals which are reviewed regularly. Goals achieved for 2020 included above 80% resident/relative satisfaction from the annual survey (the survey undertaken in October indicated 100% satisfaction).  The facility manager (FM) has maintained at least eight hours of professional development annually. In the last seven months the FM has attended an infection control study day at the local DHB, undertaken training on diabetes and electronic medication management. |
| Standard 1.2.2: Service Management  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. | FA | During a temporary absence, the director will cover the facility manager’s role with clinical support contracted in. The facility is currently seeking a registered nurse who will provide clinical support for the facility manager and also be able to cover leave. The service has operational management strategies and a quality improvement programme to minimise risk of unwanted events. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There are policies to guide the facility to implement the quality management programme including (but not limited to), a quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and an internal audit schedule. Quality information and data is discussed at the monthly staff meetings including health and safety, infection control, audit outcomes and any concerns/complaints. Staff interviewed stated they are well informed and receive quality and risk management information such as a monthly adverse event summary. All events are logged and trended. The caregivers interviewed stated they are asked for suggestions and feedback on quality initiatives.  An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed.  A quality and risk management programme is in place that includes health and safety and hazard identification. Staff report any hazards identified on the relevant form. The facility manager is the health and safety officer. On interview, the FM demonstrated a good understanding of health and safety legislation and the role of a health and safety officer. The FM is awaiting the commencement of a H&S training course. Inservice health and safety training has been undertaken by staff(June 2020) and emergency management training(Nov 2020). Hazards are reported on an accident and incident form and are checked daily. The orientation programme has been changed to include more information on health and safety including a booklet, the contents of which staff are quizzed on.  A resident/relative satisfaction survey has been completed (Oct 2020) 100% satisfaction was recorded. The survey results were collated to identify if there were any areas for improvement and results fed back to participants.  Falls prevention strategies are in place for individual residents that includes the analysis of falls and any areas for improvement. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | There is an accident/incident policy, which is part of the risk management plan. Monthly data collection of accident/incidents are completed. When an incident occurs the staff, member discovering the incident completes the accident/incident form. The incident/accident and progress notes evidence timely RN clinical assessment and identifies preventative and corrective actions. All incidents/accidents are signed off by the facility manager, who conducts a further investigation and with the director, formulates a corrective action plan if required. Twelve incident/accident forms for October 2020 evidenced detailed investigations and corrective action plans following incidents as appropriate. The Glasgow Coma scale is used to determine level of consciousness following unwitnessed falls or falls where the head may have been hit. There had been no incidents/events requiring section 31 notifications. Management were cognisant of when a section 31 is required. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (one facility manager (RN), two caregivers, one cleaner, one activities coordinator, one laundry person and one cook). The recruitment and staff selection process includes police vetting and reference checks are completed prior to employment to validate the individual’s qualifications, experience and suitability for the role. All files evidenced a signed employment contract and job description. Staff files reviewed showed staff employed by the new owners had an appraisal undertaken after three months as per policy. Annual appraisals are planned to be undertaken twelve months after ownership change. Documentation of qualifications was evident. All except two staff members have a current first aid certificate. There is an orientation programme in place and staff are orientated to their area of work and complete competencies relevant to their role including a medication competency.  Education delivered to staff is reflective of legislative requirements and the needs of the residents. Since March the following topics had been covered: infection control(repeated and also done one to one spontaneously), medication management, consumer rights, quality, accidents and incidents, health & safety, safe handling and hoist use, challenging behaviours, enabler use and what restraint is(nil use), emergencies, fire safety and evacuation, diabetes and problems of the elderly- pain, hearing, poor vision.  Of the five caregivers interviewed, four had a recognised caring qualification or were working towards it. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing rosters were sighted and evidenced that sick staff and staff on annual leave are replaced. There is a full-time facility manager(clinical) on Monday to Friday and on-call. On the morning shift, there are three caregivers on duty and one breakfast person/cleaner from 7am to 1pm. Afternoon shifts are staffed with two caregivers on full shift and one caregiver on a four-hour shift. On night shift, there is one caregiver.  An activities coordinator is on duty Monday to Friday 8.30 am to 3pm. There is a cook each day with a kitchen assistant on over teatime each day (3 hours on weekdays, five on weekends). There are dedicated laundry staff. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure office. Care plans and notes are legible and signed and dated by the RN or Care giver. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information booklet available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC. contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | 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 and this is documented. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating at the time of audit. A consent form had been signed and the resident deemed competent. The inhaler was in a drawer. There are no standing orders. There are no vaccines stored on site.  The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication competent caregivers administer all medications. Staff attend annual education and have an annual medication competency completed. The medication room and medication fridge temperatures are checked daily. Eye drops are dated once opened.  Staff sign for the administration of medications on the electronic system. Twelve medication charts were reviewed (twelve rest home). Medications are reviewed at least three-monthly by the NP or G.P. There was photo ID and allergy status recorded. As required medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has two cooks who cover Monday to Sunday between them and one afternoon kitchen assistant. All cooks have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked onsite. Meals are served directly from the kitchen. The temperature of the food is checked before serving. 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 monitor performance. Kitchen fridge and freezer temperatures were 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 and dislikes were noted. The three weekly menu cycle is approved by a dietitian. All resident/families interviewed were very satisfied with the meals.  The food control plan was verified 23 June 2020. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | 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. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | 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 not limited to) pain, nutrition and continence. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans were resident centred. Interventions documented support needs and provided detail to guide care. 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 Parkinson’s specialist, the physiotherapist, the dietitian and the mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. They also liked that the facility manager prints off information on the disease process that a resident has. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes the RN initiates a NP or GP consultation. Staff state that they notify family members about any changes in their relative’s health status. 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.  Resident falls are reported on accident forms and written in the progress notes. The caregivers are not qualified to complete neurological observations, but they monitor levels of consciousness (Glasgow Coma Scale) and notify the facility manager if they have any concerns.  Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There were currently five wounds being treated. There were no pressure injuries. Pressure injury prevention equipment is available.  Monitoring forms were in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are two activities coordinators one who works nineteen and a half hours a week and one who works thirteen hours a week. On the day of audit residents were observed listening to a newspaper reading, doing their daily exercises and listening to entertainment. Many were having their hair done by the hairdresser who comes in weekly.  There is a monthly and daily programme in large print on noticeboards in all areas. 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. Those residents who prefer to stay in their room or who need individual attention have one on one visit to check if there is anything they need and to have a chat.  There is an interdenominational church service monthly and a priest comes in every second Saturday for Catholic communion. A Salvation Army representative visits one resident occasionally.  Van outings are weekly. Special events like birthdays, Easter, Mothers’ Day, Anzac Day and the Melbourne Cup are celebrated. At present the facility is celebrating a different country and its culture monthly. Since Covid19 there has been no pet therapy, but the facility is hopeful this will start again soon. Family members do bring in their dogs. There is regular entertainment.  There is community input from the local RSA and a volunteer who does crafts with residents.  Some residents go to stroke club weekly and the men enjoy a monthly visit to the working men’s club. There are also two church coffee mornings a month. Residents who are able, also enjoy shopping and coffee outings.  There are no set activities at the weekend, but the activities coordinators leave out games, puzzles and movies.  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.  Resident meetings are held monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Except for the new admission, 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 were in place for each of the residents and these are also evaluated six-monthly. 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. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | 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 Parkinson’s specialists, mental health services for older people and the physiotherapist. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety data sheets and product sheets are available. 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. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness which expires 17 June 2021. There is a maintenance person who works twenty hours weekly. He also does the garden. Contracted plumbers, electricians and builders are available when required.  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, hallways and most bedrooms are carpeted. There are nine bedrooms with vinyl flooring. 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.  Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home level of care residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | Thirteen rooms have an ensuite. Five rooms have toilets and hand-basins. The remaining twelve rooms have hand-basins only. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in communal toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All rooms are single. 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. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | 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. There is a hairdressing salon. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is done on site. There is a laundry worker for six hours daily. There is no laundry completed at the weekends. Ironing is completed by the night. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All chemicals on the cleaner’s’ trolley were labelled. There is a small but adequate sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. There are adequate civil defence supplies including water and food storage. There is a bar b que with gas cylinder for cooking in the event of a power failure.  There is a fire evacuation scheme and six-monthly fire drills (the last undertaken by the fire service November 2020). Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.  Resident’s rooms, communal bathrooms and living areas all have call bells. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with entrances locked at 6pm with the front entrance being locked at 8pm. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. There are electrical panel heaters in all areas including residents’ rooms. Staff and residents interviewed stated that this is effective. There are two outdoor areas where residents smoke. All other areas are smoke free. |
| Standard 3.1: Infection control management  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. | FA | 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. There is an infection control coordinator (the facility manager/RN) who is responsible for infection control across the facility. The coordinator liaises with and reports to the director. 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 director.  Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IC coordinator is a very experienced RN. She has access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The NP monitors the use of antibiotics. In November 2020, the IC Coordinator attended an IC study day at the Waikato DHB. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | 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 IC coordinator and the director with input from the DHB. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | 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 participate in IC education at least twice a year and this year it has been frequent due to the Covid19 pandemic. There is a separate Covid19 IC folder with an outbreak plan and ongoing and up to date information for staff. Resident education occurs as part of providing daily cares and as applicable at resident meetings. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. Trends are identified and quality initiatives are discussed at monthly staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems are in place that are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers last reviewed February 2020. The service has a no restraint policy unless in an emergency situation. There are currently no residents using enablers. There is a restraint coordinator (facility manager) who verbalised the process should an enabler be used and showed the assessment undertaken, consent forms, monitoring undertaken and register.  Staff receive training around restraint minimisation and enabler use on orientation and as part of the annual education programme and on interview demonstrated knowledge of what restraint is. |

# 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.

|  |
| --- |
| No data to display |

# 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.

|  |
| --- |
| No data to display |

End of the report.