

Heritage Lifecare Limited - Karina Lifecare

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Karina Lifecare

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 19 January 2021 End date: 20 January 2021

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: 32

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
	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

Karina Lifecare provides rest home level care for up to 37 residents. The service is operated by Heritage Lifecare Limited and managed by a suitably experienced and qualified facility/clinical services manager who commenced the role in October 2020. This and two newly appointed registered nurses are the most significant changes to the service since the March 2019 surveillance audit.

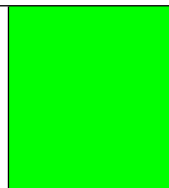
Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the facility/clinical services manager, regional operations manager, registered nurses, care staff, allied staff and a nurse practitioner who visits weekly.

This audit identified four areas requiring improvement. These relate to archiving records, documenting goals/strategies and interventions, laundry services, and review of the infection control programme.

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.

Residents of Karina Lifecare and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a very respectful manner.

Open communication between staff, residents and families is promoted, and confirmed through documentation and interviews to be effective. There is access to interpreting services if required. Karina Lifecare provides residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

Karina Lifecare has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Heritage Lifecare Limited's business and quality and risk management plans include the vision and values of the organisation. Monitoring of the services provided to the governing body is effective and occurs regularly.

A suitably experienced and qualified person manages the care facility.

The organisation's quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvements. The facility/clinical services manager collates and analyses quality data at facility level. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified, and mitigated. Organisational policies and procedures support service delivery and were current and reviewed regularly.

Appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to Karina Lifecare is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and nurse practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents at Karina Lifecare with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with 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.		Some standards applicable to this service partially attained and of low risk.
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Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen, and equipment are safely stored. Laundry is undertaken onsite. The environment meets the needs of residents and was clean and well maintained.

There was a current building warrant of fitness. Electrical and medical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints or enablers in use at the time of audit.

Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	41	0	3	1	0	0
Criteria	0	89	0	3	1	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>Karina Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Families confirmed they were made aware of the Code on admission. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

consent.		
<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>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service. Posters and brochures related to the advocacy service were also displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of the eden alternative.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 reviewed complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Boxes are available in the corridor in several places throughout the rest home for the confidential delivery of complaints and compliments.</p> <p>Review of the complaints register revealed that all the 11 complaints received since the previous surveillance audit in 2019 had been investigated, actions implemented through to an agreed resolution and completed within the timeframes. The facility manager/clinical service manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. An anonymous complaint received by the DHB in August 2020 had been investigated and found to be partially substantiated. The remedial actions required related to this complaint have been implemented and the matter was closed. There was evidence that all complaints had been closed. Documents reviewed and interviews with two managers confirmed there had been no complaints to the office of the Health and Disability Commissioner.</p>
<p>Standard 1.1.2: Consumer Rights During</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission process and welcome pack. The Code is</p>

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>displayed in the reception areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by community activities, participation in clubs of their choosing and attending resident meetings. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>	<p>FA</p>	<p>On the day of audit there were no residents who identified as Māori. Staff reflected in interviews that when they do have residents who identify as Māori, they support them to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</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,</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed (for example: preferred awake and sleep time, activity preferences, and dietary preferences). The resident satisfaction survey and interviews with residents confirmed that individual needs are being met.</p>

cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Another example of good practice observed during the audit included staff incorporating the eden alternative philosophy into everyday practice.</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>Residents and family members stated they were kept well informed about any changes to their/their relative's status, they were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English and utilising communication cards for those with communication difficulties.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>The Heritage Lifecare Limited strategic and business plans, which are reviewed annually, outline the, values, and vision of the organisation. A sample of weekly operations reports to the regional operational manager, business analyst and general manager clinical and quality showed adequate information to monitor performance is reported including health and safety issues financial performance, compliments and complaints, staffing, property issues, and general emerging risks and issues.</p> <p>The service is managed by a facility/clinical services manager who holds relevant qualifications is a registered</p>

<p>appropriate to the needs of consumers.</p>		<p>nurse and has been in the role since 05 October 2020 although they have had experience in the sector in New Zealand for several years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility/clinical services manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through the local DHB aged care forum and the Heritage Lifecare Limited organisation.</p> <p>Karina Lifecare holds contracts with Mid Central District Health Board (DHB) and the Ministry of Health (MoH) for Young Persons with Physical Disability (YPD), to provide rest home, respite, and day care. Thirty two of the 37 beds were occupied on the days of audit. Two residents were receiving services under a DHB respite agreement, 27 residents were under the DHB age related contract and three residents were under the YPD contract.</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>	<p>FA</p>	<p>Interviews with senior staff revealed that the arrangement is for the senior registered nurse (RN) to act as facility/clinical services manager, with support from other Heritage Lifecare managers in the event of the manager's absence.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system which reflects the principles of continuous quality improvement. At Karina Lifecare this includes but is not limited to; accident reporting, management of incidents, complaints and compliments, audit activities, a regular resident satisfaction survey, monitoring of outcomes such as weight loss, clinical incidents including infections, falls and medication errors.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at monthly quality and staff meetings. Staff reported their involvement in quality and risk management activities through meeting attendance, incident reporting and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Additionally, the facility/clinical services manager documented a corrective action plan in October that prioritises and describes a range of issues requiring corrective actions. These are time framed for implementation, with evaluation and monitoring notes that show progress or closure. Resident and family satisfaction surveys are completed annually. The July 2020 results revealed no major issues, although there was a low return rate of seven</p>

		<p>residents and seven relatives.</p> <p>The organisation's policies are based on best practice and were current. The document control system ensures a systematic and regular review and approval process, with referencing of relevant sources. The local distribution and removal of obsolete documents is the responsibility of the facility/clinical services manager. Hard copy policies are available for staff in the nurses' office and the RNs also have electronic access to policies.</p> <p>Both managers were conversant with and described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Documentation reviewed included a comprehensive risk management plan, and a current hazard register which includes hazardous substances. These were being monitored by the implemented health and safety system, for example the nominated health and safety officer and relevant team at monthly meetings.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form and resident related incidents are documented within the electronic system. A sample of incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. The RNs and facility/clinical services manager receive electronic alerts when actions are required to complete incident investigation and follow up actions. Adverse event data is collated and analysed by the facility/clinical services manager and reported through to the support office and operations manager. These are used for comparison with other HLL facilities and monitoring local trends.</p> <p>The operations manager and facility/clinical services manager demonstrated knowledge and understanding of essential notification reporting requirements. Notification about the change of management occurred in October 2020 and another notification related to a respite resident was notified in 03 November 2020. The Heritage Lifecare process escalates the external reporting of these to the general manager clinical and quality.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Four new staff interviewed said that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the</p>

		<p>requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Of the 17 carers employed (this number includes the diversional therapist) four have achieved level four, six have level three, five have level two and two are yet to complete a Careerforce module. There are two trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. The facility manager has also completed InterRAI training but not maintaining competency and has management access to the system.</p> <p>The new facility/clinical services manager has met one to one with each staff member in preparation for their annual performance appraisal as required in the ARCC. These are all scheduled to occur over the next two months.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster for the RNs and facility/clinical services manager is in place, with staff reporting that access to advice is available when needed. Of the 14 staff from different disciplines interviewed, all said they had adequate hours to complete the work allocated to them. On the days of audit there were four carers allocated on the morning shift for 32 residents. Two of these worked short shifts for example 7am to 11am and 8.30 to 2pm. Three carers work the afternoon shift, one starts later at 4.30pm and finishes at 8.30pm. There were two carers rostered on night shift. An RN is on site for eight hours a day (8.30-5pm) seven days a week and the facility/clinical services manager works Monday to Friday normal business hours. The maintenance person works five hours a day Monday to Friday, the diversional therapist (DT) is on site Monday to Friday between 9pm and 3pm, and there is one cleaner rostered seven days a week for six hours a day and three hours a day on the weekend. Three kitchen staff are employed and an administrator Monday to Friday. There were no laundry staff, all carers on each shift are responsible for laundry services. There is a corrective action related to laundry services in criterion 1.4.6.2.</p> <p>Residents and family interviewed were satisfied with the number of staff available at any time. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Use of agency/bureau staff is rare, one care staff was used for one night shift in the past three months. Interviews and rosters confirmed there is always at least one staff member on duty with a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	<p>PA Low</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered the electronic database. Records were legible with the</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>name and designation of the person making the entry identifiable.</p> <p>There were no clear systems for cataloguing and efficiently retrieving stored records and this requires improvement.</p> <p>No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC, GP or NP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'pink envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate transfer documentation. Family of the resident reported being kept well informed during the transfer of their relative.</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</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe electronic system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly</p>

<p>guidelines.</p>		<p>and six-monthly stock checks and accurate entries. Karina Lifecare have recently purchased two glass measures to ensure accuracy with liquid controlled drug reconciliations. Temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors which are discussed at RN and quality meetings.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Palmerston North City Council. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a telephone call and written referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as the Abbey Pain Scale, falls risk assessment tool (FRAT), skin integrity, mini nutritional assessment (MNA) and depression scale to identify any deficits to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Four of the eight care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	FA	The activities programme is provided by one trained diversional therapist (DT) who holds the National Certificate in Diversional Therapy along with rostered volunteers. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual,

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys, and informal meetings with the DT. Residents interviewed confirmed they find the programme enjoyable and meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for medication, infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house nurse practitioner', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to dietitians, specialists and district nurses. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where</p> <p>Cleaning, maintenance and care staff have completed safe chemical handling. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>

hazardous substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (26 July 2021) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The internal environment was hazard free and resident safety was promoted.</p> <p>External areas are safely maintained and were observed as appropriate to the resident group and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Review of the maintenance request book confirmed that requests are actioned in a timely manner. Residents and family members were happy with the environment.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Four resident rooms have toilets. Shower rooms and toilets are located close to resident bedrooms and common rooms for easy access. These include seven showers, one bath and eight toilets plus a staff and visitors' toilet.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water temperature testing is carried out each month. Records and interview with maintenance personnel confirmed that hot water temperatures are maintained within a safe range, for example no higher than 45 degrees celsius in resident accessible areas and higher in the kitchen and laundry.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>

consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	<p>Laundry is undertaken on site by the carers on all shifts. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Concerns were raised about the effectiveness of laundry services and this requires improvement.</p> <p>Residents and families did not express any dissatisfaction with the laundering of their clothes and there were no complaints received.</p> <p>There is a small designated cleaning team who have received appropriate training. Both cleaners have attended training in safe use of chemical, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes were being monitored through the monthly health and safety meetings. A carer and a cleaner are health and safety representatives.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff.</p> <p>Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. No changes have occurred to the building since the New Zealand Fire and Emergency Services (FENZ) approved the fire evacuation scheme.</p> <p>A trial evacuation takes place six-monthly with a copy sent to FENZ, the most recent being August 2020 and another is scheduled for 03 February 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>An extensive range of supplies for use in the event of a civil defence emergency, were sighted and meet the</p>

		<p>National Emergency Management Agency recommendations for the region. These include medical and first aid supplies, torches, batteries, radio, food, water, blankets, and gas cooking equipment. Sufficient supplies of potable water (over 500 litres for 37 residents) were stored inside and other water storage tanks are located around the complex. There is a petrol operated generator on site for use in a power outage and the battery-operated emergency lighting is automatically triggered if the power fails.</p> <p>Call bells alert staff to residents requiring assistance. A failure in the call system was alerted to the DHB on day two of the audit and strategies to minimise the risk of no call bells were immediately implemented. The system was successfully repaired. Observations during the audit and residents and relative interviews revealed that staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no security matters reported.</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 residents' rooms and communal areas were warm and well ventilated throughout the audit. Rooms have natural light and opening external windows. Heating is provided by electricity in residents' rooms and in the communal areas. Areas and residents and families confirmed the home is maintained at a comfortable temperature all year round.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>PA Low</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from management and staff. The infection control programme and manual has not been reviewed annually and this requires improvement.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality/risk committee meeting. This committee includes the facility manager, IPC coordinator, health and safety representative and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for three months. She has undertaken a post graduate certificate and attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the NP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The Karina Lifecare infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2020 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained by Karina Lifecare. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been</p>

<p>providers, support staff, and consumers.</p>		<p>provided in response. An example of this occurred when eye infections increased, and staff were given education on eye baths to reduce infections. Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance at Karina Lifecare is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager, Heritage Lifecare Limited national quality manager, IPC committee and staff. The data is available for staff in the nurse's station. Infection data is benchmarked externally within the Heritage Lifecare Group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>There have been no residents using restraints for the past four years and on the days of audit there were no residents using enablers.</p> <p>Staff interviewed demonstrated knowledge and understanding about the definitions and requirements of this standard. In service education about restraint minimisations, use of alternatives and managing challenging behaviour is provided to all staff at last annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p>	PA Low	<p>Resident electronic and hard copy records are integrated.</p> <p>Residents’ archived records are held securely on site, for example boxes of documents are stored in lockable and fire secured cupboards in the basement. There was no clear system for cataloguing and for efficiently retrieving stored records. Staff knew that these need to be stored for the required 10-year period before being destroyed, but there were so many boxes of records stored in a haphazard manner, the date range for these was unknown. The organisation uses an external agency for document destruction. Management had identified the above issues in a corrective action plan with a March 2021 timeframe for remedial action to occur.</p>	There is no clear system for categorising and retrieving archived records.	<p>Implement your corrective action plan to ensure an efficient and effective system for storage of archived records.</p> <p>180 days</p>
Criterion	PA	Review of eight care records confirmed that service delivery plans reflect the individual	Not all	Ensure that

<p>1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>Moderate</p>	<p>and identify their needs. But four of the eight records reviewed contained no goals, strategies or interventions at all, to address their needs or promote continuity of care. Two of those residents have been at Karina Lifecare since September 2020.</p>	<p>resident records contained goals and strategies to address the needs and outcomes identified during assessment.</p>	<p>each resident has a plan of care that describes the goals to achieve desired outcomes.</p> <p>90 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>Care staff are responsible for processing all laundry on each shift, for example linen and personal clothing. Staff interview, observations and documents reviewed revealed ongoing issues. For example, lost and damaged personal items of clothing and staff expressed frustration about no clear coordination of the process. The system relies on whomever was passing the laundry room to check on wash and drying cycles. There were six residents who required daily bed linen changes, which staff said increases their laundry workload. Visual inspections and interviews reveal there was an adequate supply of linen available although staff reported that last year there a period of time where there were not enough wash cloths, this has since been remedied. This is rated low risk as the facility manager and operations manager developed a new roster before the audit was completed which allocates four hours a day for a dedicated laundry staff member.</p> <p>Monitoring of the effectiveness of cleaning and laundry services has recently commenced at monthly health and safety meetings. A cleaner and a carer are nominated as representatives at these meetings to report matters as they arise.</p>	<p>The effectiveness of the laundry system requires ongoing monitoring and review.</p>	<p>Review all aspects of the laundry services to determine its effectiveness.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and</p>	<p>PA Low</p>	<p>There is an effective infection control programme which includes conducting regular surveillance activities. Karina Lifecare infection control program has not been reviewed as required since December 2019.</p>	<p>The infection control program has not been reviewed for</p>	<p>Ensure the infection control program is reviewed at least annually</p>

documented infection control programme that is reviewed at least annually.			over a year.	as per your policy and this standard. 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.