

Graceful Home Orewa Limited - Pinehaven Cottage

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Graceful Home Orewa Limited

Premises audited: Pinehaven Cottage

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 9 February 2021 End date: 10 February 2021

Proposed changes to current services (if any): Change of ownership.

Total beds occupied across all premises included in the audit on the first day of the audit: 29

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.

General overview of the audit

Pinehaven Cottage provides rest home and dementia level care for up to 35 residents. The facility is operated by Pinehaven Cottage Limited. The service is managed by a director/facility manager and a clinical manager. Residents and families spoke positively about the care provided.

This provisional 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, families, management, staff, a general practitioner and a clinical nurse specialist and doctor from the mental health team of the District Health Board.

The audit also established how well prepared the prospective provider is to provide a health and disability service. One of the two owners for Graceful Orewa Limited was interviewed prior to this audit. The prospective provider owns other aged care facilities in the region. The prospective provider understands the Health and Disability Standards and the Age Residential Related Care Agreement.

Areas requiring improvement from this audit relate to the completion of the six-monthly controlled drug check and water damage to the surround of a wash hand basin in the rest home area.

Consumer rights

Residents 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. The services provided support personal privacy, independence, individuality, and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There is a Maori health plan to guide staff to ensure that 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.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

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

Organisational management

Pinehaven Cottage Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Pinehaven Cottage and include a mission statement, philosophy scope, objectives, values, and goals. Systems are in place for monitoring the service, including regular reporting to the owners/directors.

The service is managed by one of the directors and an experienced clinical manager. The clinical manager has oversight of clinical services in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff, management/quality and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. An in-service education programme is provided, and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. The clinical manager and director/manager are on call after hours.

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general 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 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

A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Single accommodation is provided and some rooms in the rest home have a wash hand basin and toilet. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shading are provided.

An appropriate call bell system is available, and security and emergency systems are in place. Residents reported timely responses to call bells.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. Bedding and towels are laundered offsite and the cleaning and laundry are evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held four monthly.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. The facility has a philosophy of no restraint use. Restraints and enablers were not in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated a sound knowledge and understanding of restraint minimisation and safe practice.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. 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. There has been no infection outbreak reported since the last audit.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Pinehaven Cottage has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff demonstrated understanding of the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. 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 consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Informed consent has been gained appropriately using the organisation's standard consent form. Consent forms for the residents in the dementia unit were signed by the EPOAs and the competent residents in the rest home signed for themselves. Signed consent forms were sighted in the clinical files reviewed. Advance care</p>

		plans were sighted where applicable. EPOA documents for residents in the dementia were activated. Staff were observed to gain consent for day to day care.
<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	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 spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.
<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	Residents are assisted to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents were observed having visitors on the days of the audit and some went out for outings with their family.
<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 director/manager is responsible for the management of complaints. The complaints and compliments forms and associated documents meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and was available in the facility. Residents and families knew how to make a complaint and to provide compliments.</p> <p>The complaints register evidenced there have been no complaints received since the previous audit. Complaints is a standard item reported and discussed at staff, senior management and directors' meetings, should there be any. Staff confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family/enduring power of attorney (EPOA) interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff on admission. The Code is displayed at the reception area together with information on advocacy services, how to make a complaint and feedback forms. An interview conducted with the prospective owners demonstrated a good understanding of the consumers' rights (the Code) that they must adhere to.</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. Residents' personal belongings are labelled for easy identification and residents reported that they receive back their clothes after laundering. Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are supported to attend to community activities and to participate in clubs of their choosing to maintain their independence. The care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>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.</p> <p>Interviewed 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. There is a family room provided for family meetings if required.</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>There were no residents who identified as Maori on the days of the audit. There was a current Māori health plan developed with input from cultural advisers. The Maori health policy reflects the principles of the Treaty of Waitangi and the registered nurse (RN) stated these would be incorporated into day to day practice when required. Guidance on</p>

		tikanga best practice was available. The interviewed RN understood the Treaty of Waitangi and the need to acknowledge cultural values and beliefs for individual people who identify as Maori.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Residents' individual culture, values and beliefs were identified on admission during the admission assessment. Interviewed residents and family/EPOA confirmed that they were consulted on individual values and beliefs and staff respected these. Residents' personal preferences, required interventions and special needs were included in the care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents, family members and the general practitioner (GP) 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. These are included in the employee handbook and are discussed with all staff during orientation period. 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>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, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The annual education planner included mandatory training topics. The GP 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</p>

		good practice, though this was limited over the past year due to COVID-19 pandemic restrictions.
<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, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported 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.</p> <p>Information on availability of interpreter services when required is included in the admission agreement. Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English and the use of family members.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Pinehaven Cottage Limited is responsible for the services provided and is privately owned and operated. Four directors are involved in the business. A business plan 2020-2022 was reviewed and includes a mission statement, philosophy, business objectives, vision, values, and goals. The mission statement and philosophy of the organisation are also displayed. One of the four directors manages the service. The director/manager demonstrated a sound knowledge on all aspects of the service provided including the monitoring of performance. Director meetings are held at least three monthly and minutes evidenced a range of activities relating to the facility are discussed and reported. The director/manager stated the four directors speak daily to discuss any matters concerning the service.</p> <p>The director/manager has been in their current position for 11 months. Prior to that, another director was managing the facility. A clinical manager (CM) was appointed to the position on the 25 January 2021. The CM is an experienced manager and RN who prior to this role managed another aged care facility in the region. The CM has a current practising certificate, and the director/manager is an occupational therapist.</p>

		<p>The prospective provider, Graceful Orewa Limited consists of owners who own and operate other aged care facilities in the region including dementia level care. Both have governance and management backgrounds in the aged care sector.</p> <p>A comprehensive transition plan reviewed and interview of the prospective provider and the current owner evidenced the current owner is committed to providing a comprehensive handover during the transition period until the 31 March 2021, when it is envisaged the prospective provider will take ownership. The current owners stated they will also provide information after the change of ownership if needed.</p> <p>The prospective provider stated they have not met the staff as yet; however, they expect little change to current staffing. The prospective provider stated one of the owners will provide overall management of the service. The prospective provider has notified the District Health Board of the change of ownership.</p> <p>The prospective provider stated a mission statement and values statement will be developed with input from residents, families and staff. In the interim the current vision, mission and values will be referred to.</p> <p>Occupancy on the first day of the audit consisted of 29 residents - 19 dementia level care residents and 6 rest home level care residents under the age-related residential care contract, three residents under the long-term chronic conditions contract - two dementia level and one rest home level, and one resident under the respite contract at rest home level.</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>If the director/manager is absent, the clinical manager will cover all aspects of the service. During absence of the clinical manager one of two registered nurse is available to cover for the clinical manager. The CM is supported by the registered nurses on shift. The registered nurse is on duty seven days a week. Staff interviewed reported that the current arrangements work well.</p> <p>The prospective provider understood the needs of the different certified service types and understands the Age Residential Related Care</p>

		(ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.
<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>	FA	<p>A quality improvement and risk management plan guide the quality programme that reflects the principles of continuous quality improvement and includes goals and objectives.</p> <p>Management/quality, staff and residents' meetings are held regularly, except during the Covid 19 lockdowns when memos, emails and time target were used to provide updates and information. Meeting minutes including quality data are available for staff to read. Meeting minutes evidenced reporting of completed internal audits, quality data, including clinical indicators which are graphed. The director/manager and now the CM is responsible for the quality and risk management processes and ensuring the organisation's quality and risk management systems are maintained.</p> <p>Clinical indicators and quality improvement data are recorded on various registers and forms and were reviewed. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Data reviewed included adverse event forms, internal audits, meeting minutes, satisfaction surveys, infection rates and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed. Satisfaction surveys for 2020 evidenced residents and families are satisfied and very satisfied with the services provided.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. The organisation implemented a new system in May 2020. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Obsolete policies are archived. Staff confirmed they have been provided with the new policies and procedures and that they provide appropriate guidance for service delivery.</p>

		<p>Actual and potential risks are identified associated with human resource management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The director/manager is the health and safety coordinator and is responsible for the management of hazards. The director/manager demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p> <p>The prospective provider advised the current policies and procedures and quality and risk management plan will remain in place with the change of ownership.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form including neurological observation and falls risk assessments following accidents/incidents as appropriate. Incident/accident forms are reviewed by the RN on duty and collated by the CM. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. A log of all incident/accidents is held electronically.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction surveys confirmed this.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The director/manager advised the coroner is currently investigating a sudden death of a resident from earlier this year. The investigation involves a GP and has police involvement. The director/manager advised HealthCERT of the event during the audit. The CM advised</p>

		<p>they have advised HealthCERT of their appointment to the service.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective provider is aware of all current health and safety legislative requirements and the need to comply with these.</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>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>The education programme has been the responsibility of the director/manager and is now the responsibility of the CM. In-service education is provided for staff in several ways including at least monthly sessions, toolbox talks at handover, specific topics relating to resident's health status and staff meetings. Education is also provided by external educators. One of the two RNs is the palliative care link nurse between the service and the local hospice.</p> <p>Individual records of education are held on staff files. Competencies were current including medicines, fire safety and personal cares. Attendance records are maintained. The two RNs are interRAI trained and have current competencies.</p> <p>A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. All care staff have completed the dementia specific modules.</p> <p>An orientation/induction programme is in place and all new staff are required to complete this prior to their commencement of care to residents. New care staff are 'buddied' with an experienced caregiver for at least two shifts. Orientation for staff covers all essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including</p>

		competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The managers reported they consider dependency levels of residents and the physical environment. The director/manager and the CM work full time Monday to Friday. Both RNs are experience in aged care, one has been employed for a year and the other for four years. The RNs are based in the dementia unit and work an eight-hour day covering seven days a week. The two RNs overlap on Wednesdays and complete a comprehensive handover. Six caregivers are rostered on the morning shift (three in the dementia unit and three in the rest home). Four caregivers are rostered on the afternoon shift (three in the dementia unit and one in the rest home). Three caregivers are on the night shift (two in the dementia unit and one in the rest home). There is a casual pool of caregivers and a bureau is used as a last resort. Caregivers are responsible for managing the laundry. The director/manager is responsible for all maintenance and takes care of the gardens. Three activities coordinators job share and cover seven days a week in both the dementia unit and rest home. The RN, CM and the director/manager are on-call after hours.</p> <p>Care staff interviewed reported there is adequate staff available and that they can get through the work allocated to them. Residents and families reported they are happy with the staffing levels and staff provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.</p> <p>The prospective provider intends to maintain the current staffing levels and skill mix. The prospective provider understood the required skill mix to ensure rest home and dementia level residents needs are met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately</p>	FA	Residents' information is in electronic form for care plans, interRAI assessments, GP notes and incident reports. Progress notes, initial

<p>recorded, current, confidential, and accessible when required.</p>		<p>admission assessments and admission agreements were paper based. 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 in the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. The residents' files were kept within the locked nurses' stations.</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>Admission enquiries are managed by the receptionist and the directors. Enquiries were documented and follow ups were completed by the receptionist and the enquiry list updated with outcome of the enquiry. 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 and family/EPOA for residents accessing respite care.</p> <p>Pinehaven Cottage brochure and information on the facility's website have detailed information on the services provided by the service. 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. Residents in the dementia unit were admitted with the EPOA's consent. Their admission agreements were signed by the EPOAs. The EPOAs for residents in the dementia unit have consented for specialist referrals.</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>The RNs manage the exit, discharge or transfer, with an escort provided as appropriate. The service uses the DHB's 'yellow 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/whanau/EPOA. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals were documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed adequate information was shared to allow continuity of care. Family of the resident reported being kept well informed during the transfer of their relative.</p> <p>The clinical manager reported that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management policy is current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. There was a safe system for medicine management using an electronic system observed on the day of audit. The RN and the caregiver observed administering medicines 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 had current medication administration competencies.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and conducts medication reconciliation when residents return to the facility from acute services or external appointments. The RN reported that expired and unwanted medicines are returned to the pharmacy for disposal. Clinical pharmacist input is provided on request. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p>

		<p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The three-monthly GP reviews were consistently recorded on the electronic medicine charts. Standing orders are not used. The electronic prescription charts had current photos for residents' identification and allergies were documented.</p> <p>There were no residents who were self-administering medications at the time of audit. There is a policy in place to guide staff to manage this safely if required.</p> <p>Medication errors were documented, and corrective actions were implemented.</p> <p>There are controlled drugs kept on site. The six-monthly controlled drugs stock checks were not being completed.</p>
<p>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.</p>	<p>FA</p>	<p>The food service is provided on site by three cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four weekly cycle and has been reviewed by a qualified dietitian within the last two years.</p> <p>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 the local city council. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cooks have completed relevant food handling training and competency checks.</p> <p>Nutritional assessments were completed 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. Nutritional supplements were provided for residents with loss of weight issues. Residents in the secure unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, was available.</p>

		Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. The food was served in the respective dining rooms and residents were offered extra servings if desired. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The administrator reported that 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. When entry to the facility is declined, the prospective resident and or family are informed of the reason for the decline and of other options or alternative services if required.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Information was documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and continence, to identify any deficits and to inform care planning. Monthly nursing observations were completed and documented. Six-monthly interRAI reassessments were completed in a timely manner. All residents had current interRAI assessments completed by two trained interRAI assessors on site. The sample of care plans reviewed had an integrated range of resident-related information. Residents and families confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The 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 care plans reviewed. Behaviour management plans were completed for residents in the dementia unit, with appropriate interventions documented.</p> <p>The care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations</p>

		clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Short term care plans were completed for acute conditions and were closed off when conditions resolved. Residents and families/EPOAs reported participation in the development and ongoing evaluation of care plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	The reviewed documentation, observations and interviews verified that the care provided to residents was consistent with their needs, goals and the plan of care. The interviewed GP verified that medical input was sought in a timely manner, that medical orders are followed, and care was implemented promptly. The caregivers 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.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by three activities coordinators seven days per week with the support of one of the directors who has previous experience as an occupational therapist. Residents' needs, interests, abilities and social requirements are assessed on admission using a social assessment and history form that is completed by the family or by the activities coordinator with input from resident, family and /EPOA.</p> <p>Activities assessments were regularly reviewed by the activities coordinator. The director oversees the programme and helps to formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated when there is significant change in their participation in activities and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events were offered. Residents and families/whānau were involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme satisfactory. Residents were observed</p>

		<p>participating in a variety of activities and others going on outings with family.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. The residents had free access to the secure garden. Activities are offered at times when residents are most physically active and/or restless. This includes short walks in the secure garden, van outings, pamper session, noodle games, colouring, arts and crafts, music and ball handling. The activities coordinator reported that the activities are flexible and can be changed to meet the needs of the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The caregivers document in the progress notes in each shift. Any changes noted were reported to the RN. This was verified in the residents' files reviewed. Routine care plan evaluations were completed six-monthly following interRAI reassessment, or as residents' needs changed. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Completed short-term care plans were sighted for wound, urinary tract and respiratory infections. Unresolved problems were added to long term care plans. 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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health team, dietitian, eye specialists and physiotherapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. For residents in the dementia unit, the EPOAs were involved. Any acute/urgent referrals were attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictated. Referral documentation was sighted in the</p>

		reviewed records.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register was current.</p> <p>Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness is displayed that expires on the 26 September 2021. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs.</p> <p>There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by the director/manager. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are maintained within the recommended range.</p> <p>The particle board surrounding one of the wash hand basins in the rest home is in need of replacement due to water damage.</p> <p>There are external areas available that are appropriate to the resident groups and setting. The dementia unit has a large external courtyard with a covered area for residents to frequent. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p>

		The prospective provider stated there are currently no plans for any environmental changes to the facility.
<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	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Four rooms in the rest home area have ensuites consisting of a toilet and wash hand basin. There are additional toilets and showers near the residents' rooms. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photographs and other personal items on display. All bedrooms are large enough for residents and staff and equipment to manoeuvre within.</p> <p>There is adequate room in the facility to store mobility aids, such as mobility scooters, wheelchairs and walkers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to frequent. The dining and lounge areas in both units have adequate space and enable easy access for residents and staff. Residents can access areas for privacy. The furniture in the lounges and dining rooms is appropriate to the setting and residents' needs.</p> <p>There is adequate space to accommodate wheelchairs in the dining room and lounge if required in the rest home area.</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</p>	FA	Bed linen and towels are contracted out to an external company for laundering. Caregivers are responsible for undertaking the rest of the laundry including residents' personal clothing. Care staff demonstrated

<p>being provided.</p>		<p>a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen. Residents and families interviewed reported the personal clothes are managed effectively and returned in a timely manner. There are separate named baskets for each individual resident.</p> <p>The facility is cleaned to a high standard. An enthusiastic cleaner demonstrated good knowledge of the cleaning processes and has received appropriate training. Chemical are stored in a lockable cupboard and were in appropriately labelled refillable containers. The cleaning trolley is stored securely when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 24 August 2016. A fire evacuation drill takes place at least four monthly with a copy sent to the New Zealand Fire Service. The last trial was held on the 12 November 2020 and staff complete a quiz. The director/manager reported they complete fire drills more often than six monthly due to being situated in the countryside. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage meets the requirements for the emergency water storage recommendations for the region. There is a generator on site that is tested regularly.</p> <p>Call bells alert staff to residents requiring assistance and in the dementia care area staff have a pager that is connected to a system that alerts them to any resident who wanders out of their room. Call</p>

		<p>bells were observed in service areas within the facility.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the facility is checked by staff. Sensor lights are situated externally and the carpark has lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Heating is provided by under floor heating. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Pumps are used to cool the facility in hot weather. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. Both the building and outside areas are smoke free.</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>	FA	<p>Pinehaven Cottage has implemented 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 external expert services. The infection control programme and manual were reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in the infection prevention and control policy. Infection control matters, including surveillance results, are reported monthly to the clinical manager, and tabled at the heads of department/management and quality improvement meetings.</p> <p>There is signage at the main entrance to the facility that 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>There was a COVID-19 pandemic plan in place and current information on infection control measures and contact tracing requirements were implemented.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge, and qualifications for the role. They have 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 GP 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.</p> <p>Adequate resources to support the programme and any outbreak of an infection were available on the days of the audit.</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>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 2020 and include appropriate referencing.</p> <p>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. The interviewed staff 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 providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education in 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 was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in respiratory infections. Additional education was conducted during the COVID-19 pandemic.</p> <p>Education with residents was on a one-to-one basis and has included</p>

		reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, the upper and lower respiratory. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans were discussed at handover, to ensure early intervention occurs. This was verified by the interviewed caregivers.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identify trends for the current year, and comparisons against previous months and this was reported to the clinical manager and the directors. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has a philosophy of no restraint use. There were no residents using restraint or enablers during the audit. Enablers were the least restrictive and used voluntarily should a resident request one. The director/manager demonstrated good knowledge relating to restraint minimisation. There is a restrain/enabler register should one be required. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries were evidenced on the days of the audit. However, there was no evidence of six-monthly stock take checks as required.	The six-monthly controlled drugs stock checks were not being completed.	<p>Provide evidence of six-monthly controlled drugs stock checks in June and December each year.</p> <p>60 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	The internal environment is appropriate to the resident groups with lots of room for safe walking. The rest home external area has shade cloth and seating. The dementia unit has a large external area with a covered area for residents to enjoy and is secure. The environment is conducive to the range of activities undertaken in the areas. Residents	The paint has lifted on the particle board surrounding a basin in the rest home and is damaged due to water seepage.	Provide evidence that the boards surrounding the basin in the rest home have been replaced and painted to prevent future water damage.

		<p>are protected from risks associated with being outside.</p> <p>The surrounds of a basin in the rest home, mainly used by staff, has the paint lifting at the back and front of the basin. The particle board is exposed, and water has penetrated into the board making it wet and soggy.</p>		60 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.