

Lara Lodge 2017 Limited - Lara Lodge

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 HealthShare 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: Lara Lodge 2017 Limited

Premises audited: Lara Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 8 March 2021 End date: 9 March 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: 20

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

Lara Lodge can provide rest home level care for up to twenty-three residents. The rest home is privately owned by the two directors. Organisational performance is monitored.

This certification audit was conducted against the Health and Disability Service Standards and the organisations contract with the District Health Board (DHB). The audit process included the review of policies and procedures; a sample of resident and staff files; observations, and interviews with family, management, staff, two general practitioners (GP's) and the owners/directors.

There were two areas requiring improvement regarding assessments and menu review.

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.
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Lara Lodge provides care that reflects the Code of Health and Disability Services Consumer Rights (the Code). Information about the Code is promoted and shared with residents, family/whanau members and staff. Residents are encouraged to maintain cultural

values and beliefs and connections with their community. Care and support are delivered in line with good practice. There is open communication between staff, residents, and family/whanau. Access to interpreter services is provided if required.

There are processes in place for gaining informed consent and residents' choices are respected. Residents and family/whanau advised that the staff treats them with dignity and respect. The complaints process meets consumer rights legislation. A complaints and concerns register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The purpose, values, scope, direction and goals of the organisation remain the same. The business and strategic plans have been reviewed. The owners/directors are supported by the clinical nurse lead, nurses and experienced health care assistants. The required policies and procedures are documented and available. There is a quality plan with key quality objectives. A range of quality data is collected. An internal audit schedule is implemented. Adverse events are managed in line with best practice and reported as required.

Human resource policies and procedures are in place and are implemented. The 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 reviews. Staffing levels and skill mix meet the needs of residents.

Residents' information is securely maintained, integrated, current and up to date.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Entry to the service is managed in an appropriate and efficient manner with relevant information provided to the potential resident/family. Each stage of service provision is provided by suitably qualified personnel in a timely manner. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The files reviewed demonstrated that the care provided met the needs of the residents and relevant people including residents and family where appropriate, were consulted. 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. The medicine management system implemented complies with legislation, protocols and medicine guidelines. The food services are provided onsite with special needs catered for. Food is safely managed. Residents expressed 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.		Standards applicable to this service fully attained.
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The building is appropriate to the needs of the residents. There is a current building warrant of fitness. All equipment was observed to be in good working order. Well-furnished communal areas, dining and external areas are accessible to all residents. The facility has plenty of natural light and is maintained at a comfortable temperature. Bedroom areas are sufficient in size to allow for personal possessions and accommodate mobility aids, equipment and staff caring for the resident. Toilet and bathroom facilities are

sufficiently equipped and well maintained. Maintenance is maintained in an ongoing manner. Applicable building and fire regulations are met.

Cleaning and laundry service meet infection control requirements and are of a good standard. Collection, storage and disposal of waste is in accord with council and infection control principles. Staff comply with safe waste and hazardous substances procedures.

Appropriate processes are in place to maintain the safety and security of residents at all times. The organisation has sufficient supplies in the event of an emergency or pandemic.

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 documented policies and procedures that support the minimisation of restraint. There were no residents using restraints or enablers on the day of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff education on restraints, enablers and the management of challenging behaviour is provided.

Infection prevention and control

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

The type of surveillance is appropriate to the size and complexity of the service. Infection data is collected, recorded, analysed 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	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The residents confirmed that services provided are in accordance with the consumer rights legislation. The staff understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and how it is implemented into everyday practice. Staff were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Staff have received training on the Code as part of the orientation and in ongoing annual training. This was verified in training records sighted.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The informed consent policy and procedure meets requirements and provides guidance to staff. Signed consent forms and resuscitation treatment plans were sighted in the residents' files, including use of advance directives. Enduring power of attorney (EPOA) documents were sighted for the residents who are unable to consent. Staff were observed to gain consent during care provision. Staff understood the principles and practice of informed consent.
Standard 1.1.11: Advocacy And Support	FA	Information on advocacy and support is provided to residents and their family/whānau as part of the admission process. Posters and brochures related to the advocacy services were displayed and available in the facility. Family members and residents were aware of the advocacy service,

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		how to access this and their right to have support persons of their choice.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents have access to community services and receive visits from family and friends as desired. Family/whanau were observed picking up their family member for community outings and support is provided for residents to access specialist appointments as required. Records of visitors were maintained and phone communication with family/whanau were documented. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family/whanau stated they felt welcome when they visited and comfortable in their dealings with staff and management.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure meets consumer rights legislation and is explained to residents and family members as part of the admission process. Family members and residents confirmed that management has an open-door policy which makes it easy to discuss concerns at any time. There are additional processes for obtaining resident and family feedback. Resident satisfaction is monitored and resident meetings are conducted which provide residents with ongoing opportunities to discuss any day to day concerns and provide management with feedback. There is a complaint register. There have been no formal complaints made during the last certification period. It was also reported that there have been no complaints to external agencies.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family/whanau receive information regarding their rights on admission as part of the admission pack given to them. Explanations of consumer rights is provided by the admitting nurse. Signed admission agreements includes information on the Code. Posters of the Code were displayed on notice boards around the facility. Residents reported awareness of their rights when receiving care. Pamphlets with information about the Nationwide Health and Disability Advocacy Services and complaint forms were displayed at the entrance foyer and were easily accessible to residents.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect	FA	All residents have single rooms which maintains their dignity during care by providing physical, visual, and auditory privacy. Residents' personal belongings are documented and labelled on admission and are kept securely in residents' rooms. Residents and family/whanau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality,

<p>and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>and choices.</p> <p>Staff maintained privacy throughout the audit. In interview, the general practitioner (GP) confirmed that residents' medical examinations are conducted in residents' bedrooms. There is a policy on abuse and neglect and annual training on abuse and neglect is provided for all staff. This was confirmed in staff interviews and training records sampled. There were no documented reports of abuse and neglect and staff were aware of the reporting requirements if any alleged abuse or neglect is suspected.</p> <p>Residents are supported to maintain their independence. Individual values, beliefs and cultural needs are identified during the assessment process and are incorporated into everyday practice. This was evident in the resident's records.</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>The residents who identified as Māori reported that the care provided respects and acknowledges their cultural values and beliefs. The Māori health policy referred to the Treaty of Waitangi, barriers to access and national health strategies. Service provision supports and acknowledges the importance of whanau/family involvement as evidenced in the residents' files and confirmed by family. Guidance on tikanga best practice is available and is supported by staff who identify as Māori. The clinical nurse leader reported that they have access to cultural advisors through the DHB if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents' individual values and beliefs including ethnic, cultural and spiritual beliefs were identified during the admission assessment. The identified needs were documented in the residents' care plans. The residents and family/whanau confirmed being involved in the assessment process and confirmed that their cultural values or spiritual beliefs are safely met. Staff have received training on cultural safety as verified in the training records. There were policies and procedures to guide staff in providing care in a culturally safe manner.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members 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, discrimination or inappropriate behaviours.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies and procedures promote good practice and are evidence based. There are treatment protocols in place based on best practice rationales, which are monitored and evaluated. Staff demonstrated awareness of how to access the information if required. Ongoing education is provided for all staff and mandatory topics are covered by the education plan. External providers are involved in the education programme when required. Training records were sighted. The local DHB supports the service when required and the GP confirmed that prompt and appropriate medical intervention is sought when required.</p> <p>The incident reporting system is linked to the quality system and reflects open disclosure. The incident records sampled confirmed that family/whanau were advised in a timely manner. Residents and family members reported satisfaction with the services provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The communications manager and the clinical nurse lead stated that there is an open-door policy and residents and family can communicate with the managers when required. This was confirmed in interviews with residents and family/whanau. Open disclosure was evident in the adverse events records reviewed. Residents and family/whanau stated that they were kept well informed about any changes to health status and changes made to medical treatment. The service has access to interpreter services through the DHB and can rely on family members and staff if required. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</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>	<p>FA</p>	<p>There are two owners/directors. One director is the facility manager and the other the communications manager. The communications manager is responsible for human resources and some quality activities and the facility managers oversees maintenance, grounds and facilities. The owners/directors are supported by an external accountant, who also consults on health and safety matters, and the clinical nurse lead. Lara Lodge management attend provider meetings and also belong to a national group of smaller aged care providers who provide ongoing support and newsletters.</p> <p>Organisational performance is monitored by the owners/directors who are both on site seven days per week, business hours, and as required. Both owners/directors were interviewed and confirmed their day to day involvement in the business, plus their availability after hours. The philosophy, code of ethics and values of the organisation are documented and are being reviewed in an ongoing manner. The business plan and strategic direction has been reviewed.</p>

		<p>On the day of audit, there were 20 residents requiring rest home level of care and two residents who were under the age of 65 years. The service can also provide care for residents identified under the long-term support - chronic health conditions contract or palliative care, respite care and day care. There were no residents requiring care under these contracts on the day of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical nurse lead, registered nurse and enrolled nurse would be delegated duties in the absence of the owners/directors. The clinical nurse lead has been in the role for four years. The clinical lead is supported by the other registered nurse and maintains the required professional development hours including accessing relevant training topics provided by the DHB. There is also an experienced health care assistant who has been with the organisation for 20 years. The accountant/health and safety person would also be able to provide support for any planned absence. Roles and accountabilities are documented on the organisational chart.</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>	FA	<p>The required policies and procedures are documented. Policies reflect current good practice, legislation and compliance requirements. Policies and procedures are accessible to staff. There is a system for updating, reviewing, approving, controlling and removing obsolete documents. Policies are personalised to Lara Lodge and reflect the scope of the organisation. Clinical policies are reviewed and updated by the registered nurses.</p> <p>There is a 2021-2022 quality plan with defined objectives. This includes responsibilities, timeframes and actions. The 2021-2022 plan has been reviewed with some activities carried over from the previous plan if not completed. A range of quality related data is gathered. This includes resident feedback, infection control surveillance, health and safety, adverse events and internal audits. Staff meetings include discussions on quality data and the results of internal audits are routinely being discussed at both leadership and staff/clinical meetings.</p> <p>The internal audit schedule is implemented. Checklists for internal audits are utilised. There is evidence that corrective actions are documented and implemented where a variance is identified. Information regarding resident satisfaction (meals, activities, cleaning and laundry) is included in the internal audit programme. Resident satisfaction audits confirmed general satisfaction with the services provided.</p> <p>A risk management plan is documented. It was reported that risks are discussed regularly between the clinical lead and owners/directors. Financial accounts are audited annually and the required insurances are in place. Health and safety requirements are being maintained, including hazard identification. Health and safety requirements are also maintained through routine checks</p>

		of the premises each month. Clinical risk is documented in individual resident records.
<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>The clinical nurse lead and communications manager are aware of situations in which the service would need to report and notify statutory authorities. Adverse event records confirmed that incidents and accidents are being reported and followed up in an appropriate and timely manner. Records included evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner. Family members confirmed that incidents are reported in a timely manner. There was also evidence of open disclosure in the event that an error had occurred, for example a medication error.</p> <p>All adverse events are entered onto a monthly register. This is analysed annually and is compared with previous annual results. The majority of adverse events has been falls, with a falls prevention programme in place. Collated events are discussed at staff meetings.</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>The organisation employs 22 staff, the majority of whom are health care assistants. There are two registered nurses, one of whom is the clinical nurse lead, and one enrolled nurse. There are designated staff for domestic duties. Human resource policies and procedures are in line with employment legislation.</p> <p>Staff records included an employment agreement and a position description. Staff have criminal vetting prior to appointment, reference checking and professional qualifications are validated. All staff receive an orientation. The orientation programme includes the essential components of service delivery and all new staff are buddied by a senior member of the team until they are assessed as competent. Orientating staff are additional to the roster.</p> <p>A training plan is documented and implemented annually with regular training sessions offered. Ongoing education includes the required DHB topics. Staff are provided with both internal and external training. The clinical nurse lead, the enrolled nurse and registered nurse have completed the interRAI training. Mandatory competencies include medication, manual handling/hoist training, restraint and handwashing. The required competencies were sighted in staff files sampled. Staff can access care training online, which is overseen by the enrolled nurse, who is the designated training champion. The nurses maintain their professional portfolios. Performance appraisals are completed for all staff and this ensures that any individual training needs are identified.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The process for determining staffing levels and skill mix is defined in policy and considers the layout of the facility. Staff rosters are developed by the communications manager with oversight from the clinical nurse lead. Rosters sampled confirmed that there are sufficient numbers of staff to meet the needs of the residents, with shift gaps covered in the event of a temporary absence. The clinical nurse lead and the enrolled nurse are on site 40 hours per week. The clinical nurse lead and the owner/directors are on call after hours. There is a staff member on shift with a first aid certificated.</p> <p>There are two health care assistants on duty during the day shifts and one staff member on duty during the night. The clinical lead and activities coordinator are additional to the roster. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents' information is accessible in hard copy and electronic records for care plans and interRAI assessments. Residents' files were comprehensively documented including all the necessary demographic, clinical and health information. Staff have individualised passwords to access electronic information. All information is maintained in a secure manner. Personal information, other than a name on the residents' bedroom door, was not publicly accessible. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Entries into residents' records are made daily. All entries sighted were legible, included the time of entry and the writer's designation. The resident's name was identifiable on each page. There are two folders in use, one for the medical personnel and allied health providers and a clinical file for all documentation from the nursing team and activities team. The clinical nurse lead reported that when residents go for GP visits, they take the medical file with them for the medical personnel to document in. The two files are cross referenced to each other. Adverse event reports were also filed into the resident's clinical folder once they had been investigated, closed and added to the data base.</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>Entry to services is managed by the communications manager and the clinical nurse lead. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination Service (NASC). NASC assessment records were sighted in the residents' records. 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. Updated information is obtained from NASC and the general practitioner (GP) for residents accessing respite care.</p>

		<p>Family/whanau and residents stated they were satisfied with the admission process and the information that had been made available to them on admission. Completed demographic details and signed admission agreements in accordance with contractual requirements were sighted. 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>	FA	<p>Exit, discharge or transfer processes are managed by the nursing team and the GPs where required. The DHB's 'yellow envelope' system is used when residents are transferred to and from acute services. The transfer documents sighted in residents' files evidenced that appropriate information was provided for the ongoing management of the residents. Residents' and family/whanau reported being kept well informed during transfer. There is a clause in the admission 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>	FA	<p>The medication management policy complies with the legislation and guidelines. A safe system for medicine management using a manual paper-based system was observed on the days of audit. The healthcare assistant observed administering lunchtime 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. Medication errors were documented, and investigations completed with corrective actions implemented as required.</p> <p>The medicines are stored safely in the locked cupboard in the nurses' station and medication trolleys. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN completes medication reconciliation when new packs are delivered from the pharmacy and when residents return to the facility from acute services. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>There were no controlled drugs on site on the days of the audit. There is secure controlled drugs storage cupboard in place. The controlled drug register provided evidence of previous weekly and six-monthly stock checks entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Three-monthly medication reviews were consistently completed by the GPs on the medicine charts reviewed. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for 'as required' (PRN) medicines were evidenced on the charts.</p> <p>There were two residents who were self-administering medications at the time of audit.</p>

		Appropriate processes were in place to ensure this was managed in a safe manner.
<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>	PA Low	<p>The food service is provided on site by a chef and two cooks. The chef and the two cooks have received food safety and food hygiene training. The chef is responsible for food procurement through external approved food providers. The kitchen staff were observed practising appropriate food hygiene practices during food preparation. The service operates with an approved food safety plan and registration issued by the ministry of primary industries (MPI). Food, fridge, and freezer temperatures were monitored and recorded as part of the plan. The kitchen was clean, and the pantry had adequate stock to cover for emergencies. Leftover food in the fridge was covered and labelled.</p> <p>The RNs complete a nutritional requirement form on admission for all residents to identify residents' food requirements including likes, dislikes, allergies, any special diets, or modified texture requirements. A copy of the diet profile is given to the kitchen staff. Diet profile copies were sighted in the kitchen file. The kitchen staff are advised of any changes to the nutritional requirements, this was verified in the records sighted in the kitchen file. The personal food preferences, any special diets and modified texture requirements were accommodated in the daily meal plan. This was verified by residents and family/whānau in interviews conducted, satisfaction surveys and residents' meeting minutes.</p> <p>Meals were served attractively in portion sizes that the residents required. Alternatives or additional serves were provided as requested. The residents confirmed satisfaction with the meal service.</p> <p>An improvement is required regarding menu review.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The communications manager and the clinical nurse lead reported that if a referral is received and 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. The reason for the decline is shared with the prospective resident and/or family/whānau.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	PA Low	<p>Validated nursing assessment tools such as pain scale, falls risk, pressure area risk, nutritional screening and continence are used to identify abilities and any deficits to inform care planning.</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>Care plans had an integrated range of resident-related information. All residents interRAI assessments were completed six-monthly and the triggered outcome scores were used to support care planning. Residents and family/whanau confirmed their input and involvement in the assessment process.</p> <p>An improvement is required regarding assessment for one resident who had had a significant change in care needs.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the assessments were reflected in four of the five care plans reviewed (refer criteria 1.3.4.2). The care plans included information from the medical team, allied health professional, activities team and the nursing team. Changes in care were documented and verbally passed on to relevant staff. Residents and families/whanau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Residents and family/whanau confirmed that the care provided met their needs. Documentation in residents' records verified that individual needs were met. The GPs verified that medical input was sought in a timely manner that medical orders were followed, and care was provided as prescribed. Care staff confirmed that care was provided as outlined in the documentation. Adequate resources were available, suited to the level of care provided and in accordance with the residents' needs. This included a hospital bed and hoist for the one resident who requires assessment for a higher level of care.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by the activities director (AD) and two activities coordinators. The AD completes the activities needs assessment for all residents on admission with input from residents and family/whanau. Residents' needs, interests and social requirements were documented in the activities plans. The activities programme was posted on the notice boards and a copy was posted in each resident's room. The activities reflected ordinary patterns of life and included normal community activities. One on one, group and regular events were provided. The activities included church services, external entertainment, board games, quiz, gardening, walks, exercises, and van outings.</p> <p>The activities for the under 65 residents were suitable for their needs and their abilities. These were in conjunction with specialist services. These residents can join in the group activities on the</p>

		<p>programme if desired and one on one activities were provided as required.</p> <p>The activities care plans were reviewed six-monthly as part of the six-monthly care plan review. The residents and their family/whanau were involved in evaluating the activities programme through monthly residents' meetings and annual satisfaction surveys. Residents and family/whanau confirmed satisfaction with the activities programme. Residents were observed participating in various activities on the days of the audit.</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 health care assistants documented daily residents care in the progress notes and any changes were reported to the RN. The RNs review the progress notes and document weekly. Long-term care plans were evaluated six-monthly and indicated the degree of response to planned interventions. Where the required outcomes were not met, the service responded by changing the plan of care (refer criteria 1.3.4.2). Short term care plans were evaluated in a timely manner and closed off when resolved. The residents and family/whanau confirmed being involved in evaluating care and being informed of changes to care.</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 given a choice and are supported to access other health and/or disability services to meet their needs as required. Family/whanau or staff accompanies residents to GP appointments and other appointments if needed. Residents choose their own medical practitioners. Residents were referred to specialist services when required. Other health and disabilities services consultation records were sighted in the residents' records. The clinical nurse lead and the GPs reported that acute/urgent referrals were attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies and procedures include information on the management of waste and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply chemicals and cleaning products. Material safety data sheets were available and staff know what to do should any chemical spill occur. Domestic rubbish is removed as per council requirements. There is provision and availability of protective clothing and equipment (PPE) and staff were observed using this during the audit. Additional supplies of PPE are available in the event of an outbreak. Sharps containers are available. There have been no adverse events regarding 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>	<p>FA</p>	<p>There is a current building warrant of fitness. The facility and grounds are well maintained with safe internal and external areas. The rest home is divided into three main wings, with the communal area and administration at the centre of the facility. Furnishings and furniture are fit for purpose and consider the needs of the residents.</p> <p>The facility manager is responsible for maintenance and is on site each day. There is a preventative and ongoing maintenance schedule. Maintenance is fixed as problems occur. Additional routine maintenance activities include a wide range of regular checks and monitoring of the building. Testing and tagging is completed and medical devices are calibrated. Hoists and beds are checked as required.</p> <p>Residents and staff confirmed they knew the processes should any repairs or maintenance be required, that any requests are appropriately actioned and that they were happy with the environment. The hazard management system ensure any hazards are identified. A hazard register is maintained.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of toilets and bathing facilities. There is a combination of semi enSuites and shared showers. There are designated toilets for staff and visitors, and a toilet close to the communal area. Hand sanitiser is placed throughout the facility. Hot water temperatures are routinely monitored, with corrective actions as required. Residents and family/whanau interviewed expressed no concerns regarding toilet and bathing facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Each bedroom is single occupancy. Rooms are of a sufficient size to accommodate the residents' needs and any equipment if required. All private bedrooms were well furnished, including personal belongings.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p>	<p>FA</p>	<p>There is a large communal/lounge/dining area in the centre of the building. This area is used for recreation and activities. The lounge is large enough to accommodate a quiet area for those who do not wish to participate in the daily activities. The communal area/lounge is open plan and includes the dining room. All communal areas are well furnished, with adequate and suitable</p>

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		seating. These areas provide a homely setting.
<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>	FA	<p>Policies and procedures include cleaning and laundry processes. All laundry is undertaken on site by designated laundry staff. The laundry is well equipped with identified clean and dirty areas. Residents reported the laundry is managed well and their clothes are returned in a timely manner. All chemicals were stored securely and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme, resident meetings and satisfaction surveys. The facility was observed to be clean and tidy.</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 are displayed and known to staff. Disaster and civil defence planning directs the staff in their preparation for disasters and describes the procedures to be followed in the event of an emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 2008. There have been no changes to the building that would impact on the evacuation plan. Smoke alarms are installed and fire extinguishers located throughout the building. A trial evacuation takes place every six months, with an additional trial evacuation conducted recently due the need to change the evacuation site whilst work was being completed by the council on gas lines in the street. The orientation programme includes fire, emergency and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>There are adequate supplies in the event of a civil defence emergency, including a well-stocked civil defence kit. An adequate amount of emergency water and food is stored on site. The organisation has an agreement with their electrical supplier to provide emergency power in the event the mains fail. There is also a generator on site. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system checks are completed on a regular basis and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time, there are security lights outside and cameras placed inside communal areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by a combination panel heaters, with regular temperature checks maintained. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p>

<p>environment that is maintained at a safe and comfortable temperature.</p>		<p>There is a designated area for smoking well away from the building.</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>FA</p>	<p>The clinical nurse leader is the infection control coordinator (ICC) and liaises with management. The responsibility for infection control is clearly defined in the infection prevention and control policies and procedures. There are clear guidelines of accountability for infection control matters leading to the management team. Staff are advised of new or acute infections at the shift handover sessions and in staff meetings. Management of the environment minimises the risk of infection to residents, service providers and visitors. The interviewed GPs confirmed early notification by the nursing team when infection was suspected.</p> <p>The interviewed staff and residents understood processes in place to minimise the risk of infection including the current COVID-19 pandemic restrictions and contact tracing requirements. Residents, staff, and visitors suffering from, or exposed and susceptible to infectious diseases are prevented from exposing others while infectious. There is a poster at the facility entrance warning visitors to stay away if unwell with flu-like symptoms and to abide by the COVID-19 infection control measures.</p> <p>The infection control programme has been reviewed. The 2021 annual review included comparisons with last year's data, pandemic planning, staff training, ensuring policies and procedures were up to date and reflect best practice and a review of risk.</p> <p>Alcohol gel and hand sanitisers were available for use throughout the facility. The ICC demonstrated awareness of processes for prompt notification of serious infection control related issues. On the days of the audit, staff were observed practicing infection control measures during provision of care. There were no infection outbreaks reported since the last audit.</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 ICC has completed external education for infection prevention and control, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the GPs and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely referral for treatment of infections. Adequate resources to support the infection control programme was available on the days of the audit. There was no infection outbreak reported since the last audit. Current information on COVID-19 pandemic infection control measures were in place.</p>
<p>Standard 3.3: Policies and procedures</p>	<p>FA</p>	<p>There are policies and procedures for the prevention and control of infection that comply with</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>relevant legislation and current accepted good practice. The policies were last reviewed in November 2020 with appropriate referencing. The infection control coordinator demonstrated awareness of the notification requirements for notifiable diseases. Staff demonstrated knowledge on the requirements of infection control policies and practices and were able to locate policies and procedures folders. The COVID-19 pandemic plan is in place.</p> <p>Staff were observed following appropriate hand hygiene and infection control practices on the days of the audit. Hand washing and sanitiser dispensers were readily available around the facility. 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>Infection prevention and control education is conducted by the ICC, the RNs and some staff attend external infection control education sessions. This was verified in training records. All staff receive education on infection prevention and control during orientation period and in an ongoing basis annually. The content of infection control education was documented, and a record of attendance maintained. Education with residents is on individual basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather. This was verified in the short- term care plans sampled.</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>Infection surveillance activities are appropriate for the size and scope of the service. All identified infections were documented, monthly data collated and analysed. Recommendations and corrective actions to assist with reducing and preventing infections were acted upon. Short term care plans were implemented with appropriate interventions to manage infections. New infections and any required management plans were discussed at handover, to ensure early intervention occurs. Monthly surveillance results were shared with staff in staff meetings. Comparisons against previous months were conducted and the reviewed infection statistics evidenced minimal infection rates. COVID-19 pandemic contact tracing measures were 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. Records sampled confirmed that staff actively work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and management team meetings. All staff complete training on restraint minimisation and challenging behaviours. On-going education is provided. There were no residents using enablers or restraint at time of the audit. The restraint coordinator is a registered nurse.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	The chef records meals provided each day in the diary and the menu is displayed. The records reviewed evidenced that a variety of healthy appropriate meals are provided. The communications manager reported that they are in the process of contracting another dietitian to review the menu, as this cancelled last year due to the unavailability of a dietitian. This was confirmed in email correspondence. Monthly weights were completed consistently, and nutritional supplements were provided as prescribed by the GPs. At the time of the audit, there were no residents with concerns regarding weight issues.	The menu has not been reviewed by a dietician within the past two years.	Provide evidence that the menu is reviewed and in line with recognised nutritional guidelines for older adults.

				90 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	<p>The interRAI assessments were completed by three interRAI trained assessors. The interRAI summary report evidenced that there were no overdue interRAI assessments. There was one resident who had a significant change in general condition and care needs, which warranted a needs reassessment for a higher level of care, however the required reassessment had not been completed. Appropriate equipment was provided and interventions to manage the resident's increased needs were being safely implemented. An urgent referral for re-assessment was made to the NASC during the audit.</p>	<p>An interRAI reassessment for significant change in a resident's condition, and referral to the NASC for reassessment of level of care, had not been not completed.</p>	<p>Provide evidence that the appropriate assessments are completed to reflect the current level of care.</p> <p>60 days</p>

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.