

Opunake Districts Rest Home Trust - Opunake Cottage Rest Home

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 Q-Audit 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:	Opunake Districts Rest Home Trust	
Premises audited:	Opunake Cottage Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 25 February 2021	End date: 26 February 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

The Opunake Cottage Rest Home provides rest home level care for up to 22 residents. The service is operated by Opunake District Rest Home Trust and managed by a facility care manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management and staff, a general practitioner and the trust board secretary.

There were nine areas identified for improvement in relation to complaints management, three criterion in organisational management, one criterion in service delivery, assessment, evaluation food service and infection control management.

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.		Some standards applicable to this service partially attained and of low risk.
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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. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents who identify as Maori have their needs met and all cultural values and beliefs are fully considered. There was no evidence of abuse and neglect or discrimination.

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

There is a complaints process which is maintained by management however the complaints register was not up-to-date at audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The business and quality and risk management plans include the scope, vision and mission statement of the organisation have been reviewed but are waiting sign off from the trust board at the next meeting. Monitoring of the service is provided monthly to the governing body. An experienced registered nurse is the facility care manager who is learning the role and now has some support and guidance from recently appointed staff.

The quality and risk management system includes collection and analysis of quality improvements data, identifies any trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Incidents/accidents are documented and corrective actions are implemented. Any health and safety risks are identified and mitigated. Policies and procedures are in the process of being reviewed and a schedule is to be developed and implemented.

The appointment, orientation and management of staff is currently under review and support has been invested for this purpose. Ongoing training supports safe delivery of care and includes regular individual performance review. Staffing and skill mix is appropriate to meet the changing needs of residents.

Resident information is accurately documented, securely stored and is not accessible to unauthorised people.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment and equipment requiring calibration checks is completed and recorded. Communal and living spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating arrangements.

Waste and hazardous substances are well managed. Staff are provided with protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry and cleaning is undertaken on site.

Staff are trained in emergency management procedures, use of emergency equipment and supplies and attend six monthly fire drills. Residents reported a timely response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation processes are in place and the RN is the restraint coordinator. There were no residents using restraint nor enablers at the time of the audit. The restraint policy outlines that the use of enablers shall be voluntary with the intention of promoting residents' independence and safety.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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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	37	0	5	3	0	0
Criteria	0	83	0	5	5	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 Opunake Cottage Rest Home has developed policies, procedures and processes to meet the obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence with residents and maintaining dignity and privacy. Training on the Code is provided when new staff are employed and the training is ongoing as verified in the training records reviewed.
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 FCM, RN and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Resident records reviewed showed informed consent has been gained appropriately using the organisation's general consent form used for the activities programme, outings in the community, photographs and when students were in the facility. Establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented as relevant in the resident's record. At the time of admission, a discussion is had with the resident and family regarding advance directives. Staff were seen to gain consent for the day to day cares and activities. Attending activities is voluntary for residents.

<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>	<p>FA</p>	<p>On admission the resident/family/whanau are provided with a copy of the Code which also includes information on the Advocacy Service in this region. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken to were fully aware of the Advocacy Service, how to access this and their right to have support persons. The contact details of advocates were displayed on the notice board at reception.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with family/whanau and the community through Coastal Care Trust, a community organisation which is pivotal in the community, running 28 different services for the residents and population in Opunake (linked to 1.2.1). The facility welcomes visitors and encourages visits from residents' family and friends as much as possible. Restrictions for visits occurred with the national pandemic and were taken into consideration for safety of all residents.</p> <p>Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>There is a complaints, concerns and compliment policy which meets the requirements of Right 10 of the Code. The information is provided to residents and their families on admission and information was sighted in all service areas of the facility.</p> <p>The facility care manager (FCM) is responsible for complaints management and follow-up. All complaints are reported by the FCM to the board meetings. All staff interviewed confirmed a sound understanding of the complaint process in place. There has been one internal complaint since the previous audit. Compliments are reported back to staff, cards are displayed with messages and information is later filed in the complaints folder for reference as needed.</p> <p>One complaint received from the DHB 3 April was in relation to a complaint received about the Covid 19 pandemic and rules for lockdown. This was closed out by the DHB.</p> <p>The FCM reported that there has been two external complaints one complaint was received from the DHB 3 April 2020 which was in relation to a complaint received about the Covid 19 pandemic and rules for lockdown. This was closed out by the DHB. One further complaint received was initially sent directly by the complainant to the New Zealand Nursing Council (NZNC) and the complaint was referred to the Health and Disability Commissioner (HDC) office. A letter was sighted of some recommendations made by the HDC in response to the complaint. The HDC forwarded the complaint and letter back to the New Zealand Nurses' Council. The complaint was then referred by nursing council to the Nationwide Health and Disability Advocacy Service (Advocacy service) and this was actioned and information gained was positive. The complaint was closed by</p>

		<p>the HDC office but was redirected to HealthCERT and to the Taranaki District Health Board (TDHB) under Section 59 (4) so that they were aware of the concerns of the complaint. The Opunake Districts Rest Home Trust have been proactive and provided additional staff and support at governance level to ensure the organisational and management requirements are able to be effectively met. The complaint has been addressed and followed up at the time of this audit.</p> <p>When reviewed the complaints folder evidenced complaints received in the folder and relevant information about each complaint. The complaints register for The Opunake Cottage Rest Home is developed and implemented but is not current or up-to-date as required to meet the Code and this standard.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents/families interviewed reported being made aware of the Code of Rights and the Nationwide Health and Disability Advocacy Service as part of the admission process. Information provided and discussion with staff is documented in the resident's records reviewed. The Code is displayed at the entrance to the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services that take into consideration at all times their dignity, spirituality, sexuality, choices and privacy is maintained at all times.</p> <p>During the audit staff were observed maintaining resident's independence by encouraging the residents to join in activities, participate in the community and attend clubs or iwi meetings of their choice and by arranging visits to the doctor as needed. Care plans include documentation related to the resident's abilities, interests and strategies to maximise independence as much as possible.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, iwi and social needs, values and beliefs had been identified in the pre- admission assessment process. InterRAI assessment information has been incorporated into the respective individual care plans to guide staff and to meet all the needs of residents.</p> <p>Staff interviewed understood the organisation's policy on abuse and neglect, including what to do should there be any signs and/or symptoms observed. Education on this topic was confirmed to occur during the orientation programme and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as</p>	FA	<p>The Opunake Cottage Rest Home has a policy and procedure which provides adequate information to guide staff on Maori health cultural values and beliefs. Cultural diversity of Maori is recognised and staff ensure there is quality provision of Tikanga Maori and cultural choice in the provision of care. Staff support residents who identify as Maori to integrate their individual cultural values and beliefs. The principles of the Treaty of</p>

<p>Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Waitangi are incorporated into the day to day practice as is the importance and significance of family/whanau. The facility care manager (FCM) interviewed reported that there are three residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Maori. Thirteen (13) staff identify as Maori including the FCM.</p> <p>There is an individual Maori health plan and values and beliefs are acknowledged with the support of the Te Whare Tapa Whau model of care. Evidence of this process being embedded into service delivery was evident in the resident's records and care plans reviewed. Cultural advisors from the community and from iwi organisations (nine in the Taranaki region) are accessible. Residents who identified as Maori that were interviewed stated that they were very happy with the care provided and reported that staff acknowledge and respect their individual cultural needs.</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 verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and any special needs were included in the care plans reviewed, for example, the attending of church services. A service was held on the day of the audit with a good attendance of resident's and some family members. The resident satisfaction survey confirmed that individual needs are being effectively met.</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/whanau interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe in this rest home environment. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct which is part of the individual employment contract and processes in place. The FCM, the RN and the enrolled nurse (only employed three weeks previously to this audit) have records of completion of the required New Zealand Nursing Council (NZNC) Code of Ethics and training on professional boundaries (a requirement for the annual practising certificates due to the changes in this document by Nursing Council in 2017). Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow if this was compromised or should they suspect any form of exploitation was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services</p>	<p>FA</p>	<p>The general practitioner interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The service encourages good practice through providing education to staff. The in-service education programme was disrupted in 2020 however</p>

<p>of an appropriate standard.</p>		<p>staff interviewed reported that they receive management support for education to support their practice. The employment of the quality manager is a positive move to ensure all policies and procedures are reviewed and continue to evidence references to good practice guidelines such as the aged care guidelines and the newly established College of Gerontology. Support from TDHB aged care nurse specialists also evidences good practice being utilised for this service.</p> <p>Other examples of good practice observed during the audit included the acknowledging and welcoming of residents' visitors, knocking on residents' doors before entering, and day to day conversations/discussions between residents, staff and visitors.</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>Residents and family/whanau 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. The RN and staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The FCM, RN and staff know how to access interpreter service locally and through the DHB when required, although staff reported this rarely occurred due to all residents being able to speak English. Interpreters are available for those that speak Te Reo.</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>PA Moderate</p>	<p>The Opunake Cottage Rest Home is owned and operated by a charitable community trust that provides rest home level care for up to 22 residents. There were 20 rest home residents at the time of the audit. The service has funding contracts with the district health board (DHB) to provide aged related residential care including respite care and long term support chronic health conditions (LTSCHC). The organisation is a member of the aged care association and receives all updates regarding aged care issues or changes to the industry as applicable. The last resident survey results record overall satisfaction from residents and family with the care and services provided. The Nationwide Advocacy Service was contacted in response to an HDC complaint to interview residents and all were pleased with the care they received at this rest home.</p> <p>The 2017-2019 strategic plan has not been reviewed by the Board which was due July 2020. The strategic plan includes and covers the strength, weakness and opportunities and eighteen quality and development goals. The quality manager/secretary to the Opunake District Rest Home Trust Board was interviewed. The quality manager was appointed by the board as from November 2020 to assist the FCM by being responsible for the staff payroll and to review the human resource manual and include the newly implemented legislative changes required. This manual has been fully reviewed but as per 1.2.7 is yet to be approved by the board. An administrator also interviewed has been appointed by the FCM to assist with the staff records</p>

		<p>management and other administrative duties as needed.</p> <p>Care staff are supported by a registered nurse who was appointed on a short term contract to cover the clinical management role as the previous clinical manger is now the FCM. A registered enrolled nurse has been employed two weeks ago to assist with clinical duties overseen by the RN and/or the FCM. Job descriptions are provided for all staff.</p> <p>The facility care manager is a registered nurse who worked at this facility initially as a senior care giver and an RN since 2016. The FCM was appointed to this role by the board in 2018 in a temporary position and then this was position was confirmed in 2019 as a permanent position. Until the board appointed the current RN on a short term contract the FCM completed both roles at the same time learning the responsibilities of being the manager for this service. Both RNs have current practising certificates as does the registered enrolled nurse recently employed.</p> <p>An area of improvement has been identified in relation to the FCM not being able to attend for one reason or another, the required eight hours a year education and professional development related to aged care management over the last two years. The personal record of the FCH was reviewed.</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>When the FCM is absent the registered nurse (who was appointed by the Opunake District Rest Home Trust Board 17 August 2020 is available to support and to provide cover for the FCM as needed. The FCM has only been in this current role since December 2018. Previously the FCM was a senior care giver who completed her nursing training becoming the registered nurse at this facility from 2016. The FCM was placed into an interim role of FCM in February 2018 and permanently in December 2018. The previous RN resigned in March 2020. The RN interviewed is a registered nurse who has worked in the aged care sector in both Australia and in New Zealand and has management/clinical experience.</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</p>	PA Moderate	<p>A quality and risk management plan was available and is being implemented dated 2020 – 2022. This includes objectives in place, quality activities and frequency.</p> <p>The document control system, a responsibility of the FCM, is not currently maintained. Two manuals have been reviewed since the previous audit being the human resource management manual December 2020 and the internal audit manual. The human resource management manual is now awaiting approval by the board at the next board meeting.</p> <p>The internal audit manual was reviewed August 2020 and the schedule was developed for 2021. The audit schedules are divided into clinical and management. Internal audits are performed as per the schedule and</p>

<p>principles.</p>		<p>timeframes documented. Key components and key indicators of service delivery such as incidents/accidents, infection prevention and control issues are audited along with key performance indicators. Data/findings are analysed and information is shared with staff at meetings and at time of handover between shifts. Staff interviewed stated this does occur and that they were kept well informed. Staff meeting minutes sighted verified that quality and risk data is shared and discussed. Quality, risk and management, accidents/incidents, restraints, audits, staffing, maintenance are discussed as per the agenda sighted. Staff meetings are held monthly on the first Wednesday of the month. The FCM reports to the board monthly by emailing the report prior to the meeting to the board secretary. Attendance is not required by the FCM.</p> <p>Quality improvements from a clinical perspective are undertaken to meet the requirements of the standard and quality improvement records were sighted for medication management, falls risk management, wound assessments and wound care.</p> <p>Actual and potential risks are identified in the hazard register. The hazard risk assessment, risk assessment matrix and hazards register are maintained and the likelihood, consequence and rating score is documented. Actions are implemented to eliminate or minimise the risk of occurrence. Staff interviewed confirmed that they understood and implemented documented hazard identification processes. The trained health and safety officer, a senior care giver, was well informed and understood all processes and responsibilities involved. Newly found hazards are discussed, monitored and managed by the health and safety officer and the maintenance person with staff input identified.</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>The FCM interviewed ensures any adverse event reporting is dealt with immediately. Addressing incidents before they manifest into more significant events has proven to be valuable for the service. The aim of adverse event reporting was to close the 'quality loop' quickly and effectively. The incident management process is linked to the quality and risk management system. Evaluation of what corrective action has been developed and implemented and/or any trends identified are detected and improvements actioned quickly. An incident register was in place and was updated at the time of the audit.</p> <p>A sample of incident forms reviewed show these are fully completed, incidents are investigated, actioned and follow-up was completed in a timely manner. Adverse event data is collated, analysed and reported by the clinical services manager to the facility manager monthly and meeting minutes reviewed showed discussion in relation to any trends, action plans and improvements made.</p> <p>The FCM interviewed described essential notification reporting requirements. Since the previous audit one Section 31 notice was documented and sent to the Ministry of Health (MoH) and the TDHB December 2020.</p>
<p>Standard 1.2.7: Human</p>	<p>FA</p>	<p>Policies and procedures are in line with good employment practice and relevant legislation and guide the</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>human resource management processes. All human resource management policies, procedures and guidelines have been reviewed December 2020 and January 2021 and are awaiting sign off and approval from the board at the next meeting. Position job descriptions reviewed were current and defined by key tasks and accountabilities for the various roles. The quality manager (newly appointed November 2020 by the board) is responsible for advertising, receiving applications, arranging interviews, police vetting and ACC work checks in conjunction with the FCM. The FCM is responsible for validation of qualifications and practising certificates (APCs) where required.</p> <p>A sample of staff records reviewed confirmed the organisations policies are being consistently implemented and records are systematically and well maintained. The quality manager and the administrator involved with human resource management discussed the development and implementation of checklists and staff records being sectioned off for accessibility as needed application, orientation/induction information, education completed etc as a quality improvement.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported at interview that the orientation prepared them well for their individual roles and included support from a 'buddy' through their initial orientation period. Two cleaners were interviewed as one was learning the role to cover for the other cleaner who will be on planned leave for a period of time. Mandatory training requirements are clearly defined and scheduled to occur over the course of the year. The education plan was reviewed for 2021. Competencies are maintained and were recorded. Care staff have completed the required education to meet the requirements of the provider's contract with the DHB. Education records reviewed demonstrated completion of the required training for all care staff and non-clinical staff. The FCM is required to complete relevant management education which has not occurred (refer to 1.2.1) to meet the requirements of the service's agreement with the DHB. The Taranaki DHB training programme for managers in the aged care sector was sighted and the FCM aims to attend some of these study days planned in 2021 which will be very beneficial to the role.</p> <p>The FCM is interRAI trained and currently completes all of the interRAI assessments. The annual competency for undertaking these assessments was not able to be verified but has been documented as an area of improvement in service delivery (refer to 1.3.4.2). The casual RN (employed by the board) is also interRAI trained but has been requested to cover the clinical every day activities and oversee the staff over these few months. The interRAI assessments summary reviewed at audit was not current (refer to 1.3.4.2). Staff annual appraisals were in progress at the time of audit. A plan for completing the staff appraisals was developed and implemented.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	<p>FA</p>	<p>There is a documented and implemented process for determining the staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week (24/7). The rosters for one month were reviewed. Most staff work permanent shifts. There is a core of care staff who have worked at this facility for some years.</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The FCM or RN can adjust staffing to meet the changing needs of residents. An after-hours on-call roster is in place with staff reporting that this works effectively and advice is available if required. Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Residents and families interviewed supported this. The GP interviewed verified that medical advice is available Monday to Friday. Advice can be sought from TDHB after hours if needed. The resident's family/whanau are contacted and kept well informed if and when required if the needs of a resident changes.</p> <p>The rosters reviewed confirmed adequate staff cover has been provided with staff replaced in unplanned absences. The FCM is available Monday to Friday and the temporary RN covers Tuesday, Wednesday and Thursday morning with two health care assistants on the morning and afternoon shifts. Night duty there is one health care assistant. The cleaner covers Monday to Friday 9am to 1pm. The cook works 6.30am to 1.30pm and is supported by a kitchen hand 9.30am to 2pm and evening cover 4pm to 7.30pm is provided. Once a fortnight a cleaner is rostered onto the night duty to complete additional cleaning for the kitchen and dining room as per the schedule in place. The activities coordinator (currently completing Level 4 diversional therapy training) provides activities 9.45am to 3.15pm. The staff interviewed commented that any emergency situations are managed effectively. Staff have completed first aid courses and certificates were in the staff records reviewed. The RNs and senior care staff have competencies for medication management. Both RNs have competencies for female and male catheterisation and other medical and palliative care management roles.</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>All necessary demographics, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical records were current and integrated with the GP and allied health service provider records.</p> <p>Archived records are held securely on site in a dry place and are readily retrievable when needed.</p> <p>Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	<p>FA</p>	<p>Entry to services is managed by the facility care manager (FCM) and the registered nurse (RN). 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. Appropriate NASC assessment records were sighted in the residents' records reviewed. 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>services has been identified.</p>		<p>Family members and residents interviewed 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 in the files reviewed. One resident who was receiving respite care support was discharged on the first day of the audit. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in an efficient manner by the nursing team and the GP where required. The service uses the DHB's 'yellow envelope' system (a large yellow envelope that contains the information record of a resident, a copy of the resuscitation status, EPOA information if required and the letter from the GP if available) 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. The interviewed residents' family reported being kept well informed during the transfer of their relative. 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. Examples of this happening was discussed with the RN. 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>FA</p>	<p>The medication management policy in place identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using a manual paper-based system was observed on the day of audit. The HCA 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.</p> <p>The medicines are stored safely in the locked cupboard in the nurses' station and medication trolley. 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. Facilities are in place for secure storage of controlled drugs in accordance with legislative requirements. Policies and procedures were in place for guidance when required. The controlled drug register reviewed 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.</p>

		<p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were evidenced on the charts reviewed.</p> <p>There were three residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food service is provided on site by two cooks and kitchen assistants. The cooks and all staff who work in the kitchen have received food safety and food hygiene training. The main cook is responsible for food procurement through external approved food providers. The cooks were observed practising appropriate food hygiene practices during food preparation which comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the ministry of primary industries (MPI) which expires 9 April 2021. Food temperatures, 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 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 folder. The personal food preferences, any special diets and modified texture requirements were accommodated in the daily meal plan.</p> <p>Meals were served attractively in portion sizes that the residents required. Alternatives or additional serves were provided as requested. The interviewed residents confirmed satisfaction with the meal service. This was verified by the interviewed family/whanau, satisfaction surveys and residents' meeting minutes.</p> <p>The menu in use was last reviewed by the dietitian in June 2017.</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</p>	FA	<p>The FCM and the RN 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. The reason for the decline is shared with the prospective resident and/or family/whanau.</p>

appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	The service uses validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, and continence assessments to identify residents' needs on admission. Initial interRAI assessments were completed in a timely manner. The sample of care plans reviewed had an integrated range of resident-related information. Residents and families confirmed their involvement in the assessment process. One of the five files reviewed did not have a current interRAI reassessment and the interRAI assessment report showed that seven interRAI reassessments were overdue.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The reviewed 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 out of the five care plans reviewed (Refer to 1.3.4.2). The care plans evidenced integration of 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 reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The interviewed residents and family confirmed that the care provided meets their assessed needs. Documentation in the reviewed residents' records verified that individual needs were met. The interviewed GP verified that medical input is sought in a timely manner, that medical orders are followed and care is 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.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by an activities coordinator (AC) who is in the process of completing diversional therapy training. The AC completes the activities needs assessment for all residents on admission with input from residents and family. Residents' needs, interests and social requirements were documented in the activities plans that were reviewed. The activities plan was posted on the notice board and a copy given to each resident. The activities planned reflected ordinary patterns of life and included normal community activities. One on one, group and regular events were offered. The activities included church services, external entertainment, board games, quiz, gardening, walks, exercises, and van outings. The activities care plans were reviewed regularly six-monthly as part of the six-monthly care plan review. The residents and their family/whanau are involved in evaluating the activities programme through monthly residents' meetings and annual satisfaction surveys. The interviewed residents and family confirmed

		satisfaction with the activities on the programme. Residents were participating in various activities on the days of the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	The HCAs documented evaluation of residents care daily in the progress notes and any changes were reported to the RN. The reviewed 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. Short term care plans were evaluated in a timely manner and closed off when resolved. The interviewed residents and family confirmed being involved in evaluating care and being informed of changes to care. Evaluation of wound care plans was not documented consistently.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are given a choice and are supported to access other health and/or disability services to meet their needs as required. A staff accompanies residents to GP appointments and other appointments if needed. Though the service has a contracted medical services practice, residents can choose another medical practitioner if desired. Residents were referred to specialist services when required. Other health and disabilities services consultation records were sighted in the residents' records reviewed. Any acute/urgent referrals are 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented processes for the management of waste and hazardous substances. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. The maintenance person interviewed explained how the service utilises the local council recycle system for daily waste and this is collected by the council service weekly and as needed. There is a designated storage area for storing chemicals used for the cleaning and the laundry. The shed has appropriate signage in place and is locked at all times. An external company is contracted to supply and manage chemicals and cleaning products and they also provided relevant training for staff. Material data sheets (MDS) were available where chemicals are stored and used and staff interviewed knew what to do should any chemical spill/event occur. A spill kit was accessible. Any related incidents are reported in a timely manner. There is adequate provision and availability of protective clothing and equipment and staff were observed

		using this, including gloves, aprons and hats. Masks are readily available if and when needed.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building warrant of fitness is current and was displayed at the entrance to the facility dated expiry 18 December 2021.</p> <p>Appropriate systems are in place to ensure the resident's physical environment and the facilities are fit for purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate and safe standard. The testing and tagging of equipment and calibration of medical equipment was current (checked December 2020) and confirmed in documentation reviewed, interviews with the maintenance person and observation of the environment. An equipment validation report was reviewed. The one hoist, (newly purchased 9 February 2021) oxygenator, nebulisers, electric beds, electric scales are ready for use at all times. A process is in place for replacing and ordering if further supplies are required.</p> <p>The grounds are safely maintained and are appropriate for this aged care setting. The environment is conducive to the range of activities undertaken. Seating in the garden is accessible and the environment was hazard free and resident were safe. Staff interviewed confirmed they knew the processes they should follow if any repairs or maintenance were needed and that any requests are appropriately dealt with. If the maintenance person interviewed was unable to action a request the preferred tradesman contact was made and once actioned is signed off in the maintenance book reviewed. Residents reported they were pleased with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of toilet, showers and ensuite bathrooms. Only four rooms have ensuite bathrooms and these are large rooms, spacious with walk in ground level shower, toilet and hand basin being available. All individual resident's rooms have a hand basin on visual inspection. The toilets and showers are in close proximity to the residents' rooms. There are safety rails in place in all toilets and showers.</p> <p>There is a separate staff /visitor toilet available.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate space provided to allow residents to use mobility aids comfortably and staff to move within the bedrooms safely. All bedrooms provide single accommodation. There are no double rooms available. All rooms are personalised with furnishings, photographs and other personal items being displayed.</p> <p>Four resident rooms have been totally refurbished since the previous audit.</p> <p>There is a designated space in the adjoining garage to the rest home to store up to three mobility scooters when not in use and/or to re-charge the batteries. The one hoist recently purchased is stored in a designated area and did not impede walkways or create a hazard for mobile residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is one large spacious communal lounge available for residents to engage in relaxation and/or activities. The lounge has comfortable seating arrangements and a large screen television set and music corner with music resources such as a record/tape recorder, movies of interest and shelves of DVDs etc. There is a small area at reception for residents' to access if they wish to do so. The large dining room accommodates all residents and is situated close to the kitchen servery which provides a homely atmosphere. All furniture is appropriate to the setting and residents' needs are met. The furniture in the dining room is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is undertaken on site in one dedicated laundry. Facilities were readily available in the laundry sighted. Care staff are responsible for the laundry and ensure all laundry is completed during the day and put away at the end of the shifts in the resident's rooms. The clean and folded bed linen and towels are stored in the linen cupboards located in the rest home. Residents and family/whanau interviewed reported the laundry is managed well and that their clothes are returned in a timely manner. The staff interviewed had a good knowledge of the laundry processes, managing soiled linen and the clean and dirty designated boundaries in the laundry. The maintenance person ensured the lint was removed several times a day from the clothes driers when in use. Staff knew to do this in the absence of the maintenance person. After hours the care staff continue the laundry if time permits as able.</p> <p>There are designated cleaners who are fully trained, including training on infection control, products and protocols. The cleaner (two interviewed as one was orientating to the role) cover the total facility 9am to 1pm daily Monday to Friday. Staff completed light cleaning duties as able in the weekends. Material data sheets are available for all products in use. There is a chemical filling station located in the laundry. Bulk supplies are stored in the locked chemical garage storage area. The cleaner's trolley is stored in the cleaners' cupboard when not in use and this cupboard is locked at all times. Cleaning clothes are colour coded and a steam mop is available.</p>

		<p>Cleaning and laundry processes are monitored through the internal audit programme and by the contracted company representatives when they visit the rest home regularly.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known by staff. Disaster and civil defence planning duties direct the facility in their preparation for disasters and described the procedures to be followed in the event of fire or other emergencies. A flow chart was reviewed. The current fire evacuation plan for The Opunake Cottage Rest Home fire drill was held on the 13 November 2020 with the fire service being present. A report was provided to the fire service. The FCM was on leave at the time. A report was developed by the fire service for education purposes as a few new staff members present did not follow the correct procedures. This was followed up with further orientation for all staff who participated in the fire drill and an education was held on the 15 December 2020 to cover all learning points identified by the fire service. The staff orientation programme does include fire and security. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency are available. The maintenance person assists staff in ensuring all emergency resources are available for the service. Food supplies are available to meet the requirements for up to three days. Blankets, mobile phones, torches, gas barbecue were accessible to meet the requirements for a maximum of twenty two (22) residents. The emergency lighting is regularly checked. The service has a diesel generator available for emergency power, a large water tank (2000 litres) and spare water in large holders available. The water supplies meet the requirements of the Taranaki region and Council requirements. There is a large bin with all emergency resources which is checked by two staff who are responsible for the contents and availability of the supplies as needed.</p> <p>The human resource manager interviewed explained that the emergency protocols are linked with the DHB and contact details of other aged care providers are accessible in the event of an emergency in this region.</p> <p>Call bells alert staff to residents requiring assistance. Call bell system audits are completed on a regular basis as part of the internal audit schedule and residents and families interviewed reported staff respond promptly to call bells.</p> <p>The service transport van is checked regularly, serviced and has a current warrant of fitness and registration. A first aid kit is always kept in the van and is checked regularly.</p> <p>Security is maintained and staff ensure all doors and windows are locked in the evening and again checked by the night staff routinely. Close circuit television video (CCTV) cameras are installed and operating in the service areas and appropriate signage was noted and displayed for public, residents and staff view.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' individual rooms and communal areas have opening external windows with natural light. Ducted heating in the ceiling through vents is provided throughout the facility. Additional electric heaters are available in the communal areas when needed. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>PA Low</p>	<p>The FCM is the infection control coordinator (ICC). 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 board of trustees. There is a clear process for early consultation and feedback with infection control team when significant changes are proposed to practices, products or equipment. Staff are advised of new or acute infections at the shift handover sessions and in staff meetings. Meeting minutes sighted. Management of the environment minimises the risk of infection to residents, service providers and visitors. The interviewed GP confirmed early notification by the nursing team if any infection is suspected.</p> <p>Interviewed staff and residents demonstrated understanding of 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 big notice board 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>Alcohol gel and hand sanitisers were available for use throughout the facility. The IFC 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>There is no documented infection control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information</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 GP and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Adequate resources to support the infection control practices were available on the days of the audit. There was no infection outbreak reported since the last</p>

resources to implement the infection control programme and meet the needs of the organisation.		audit. Current information on COVID-19 pandemic infection control measures was in place.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. The policies were last reviewed in February 2021. The infection control coordinator demonstrated awareness of the notification requirements for notifiable diseases when interviewed. 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection prevention and control education is conducted by the ICC, the RNs and some staff attend to external infection control education sessions. Training records were sighted. All staff receive education on infection control at orientation period and on an ongoing basis annually. The content of infection control education was documented, and a record of attendance was maintained. Records were sighted. 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.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control	FA	The infection surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, the upper and lower respiratory tract. All reported infections are documented on the infection report form and are reviewed by the ICC. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against

programme.		previous month and this is reported to the board of trustees via a monthly report.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There were no residents using a restraint or enabler on the days of the audit. 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 if required. Interviewed staff demonstrated knowledge on the difference between a restraint and enabler, the authorisation process and monitoring requirements to ensure residents' safety. Staff have received education on challenging behaviour management and de-escalation techniques.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>Policies and procedures are available to guide staff and to manage complaints. Complaint forms are available at the reception area and are accessible for staff, visitors and residents. Staff confirmed that any verbal complaints they receive are passed onto the FCM. The process was followed through at audit. There is a complaints register that has been developed and implemented that addresses the requirements such as dates, type of complaint, actions taken and outcomes and date of closure or agreed solutions. Information of complaints was kept in the complaints folder but there was no evidence of the complaints reviewed being documented in the complaints register reviewed at audit.</p>	<p>The complaints manual was reviewed. A copy of the complaints process was reviewed in the front of the folder to guide staff. Two written complaints have been received in the last twelve months. The register which is maintained by the FCM does not reflect these complaints and the register has had not been updated since 04 February 2019.</p>	<p>To ensure the complaints register is up-to-date and maintained to meet the requirements of the Code and the organisation’s complaints policy.</p> <p>180 days</p>

<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>PA Moderate</p>	<p>The strategic plan reviewed provides a history, philosophy and mission statement for the Opunake District Rest Home Trust board. The trust works in partnership with the TDHB, Taranaki Hospice and Coastal care. The service promotes both independence and quality of life in a safe environment for residents. The Trust board covers all asset maintenance and development using strengths, weaknesses, opportunities and threats (SWOT) analysis methodology and has a focus and acknowledgement of marketing and promotion, community partnership, quality assurance, quality and risk management, financial control and service provision. The strategic plan has not been reviewed regularly over the 2017 to 2019 period by the trust board as no plan is in place for 2020 to 2021.</p>	<p>The strategic plan including the purpose, values, scope, direction and goals of the objectives and direction of the organisation has not been reviewed since 2018 by the trust board. There is no current up to date strategic plan with objectives set as yet for 2021 to 2022. The strategic plan has not been signed off by the trust board to be effectively implemented by the organisation.</p>	<p>To ensure the current strategic plan is reviewed, analysed and updated for 2021 – 2022 and signed off by the chairperson or a designated board member when approved prior to implementation.</p> <p>90 days</p>
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	<p>PA Moderate</p>	<p>The service agreement required the manager to attend appropriate and relevant training for management on an annual basis. The manager has attended all clinical ongoing training and education for maintaining annual nursing Council (APC) requirements. The TDHB had planned training options for FCMs for 2019 and 2020 but due to uncontrolled circumstances the FCM has been unable to attend any of these seminars or training days at the DHB.</p>	<p>The FCM appointed to the manager role in 2018 has not completed the eight hours of minimum management training required annually over the last two years.</p>	<p>To ensure the FCM attends and maintains records of any annual training attended in relation to aged care management as per the service agreement.</p> <p>90 days</p>
<p>Criterion 1.2.3.3</p> <p>The service</p>	<p>PA Moderate</p>	<p>Policies and procedures are in place for all areas of service delivery to guide staff. Manuals are accessible to staff as needed. Hard copy manuals are available. A comprehensive quality</p>	<p>The service has policies and procedures in place. Apart from one human resource</p>	<p>To ensure the policies and procedures are</p>

<p>develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>		<p>system if in place with many policies linked to other manuals. The FCM is responsible for documentation control however, has been fully immersed in the clinical and managing the day to day operation of the facility for about five months without another RN for support. An RN has recently been employed by the board to provide this support needed.</p> <p>The newly appointed quality manager discussed the process to be implemented if approved by the board. One manual the human resource manual has been reviewed and updated but is awaiting approval from the board.</p>	<p>manual being reviewed there is not a current plan to ensure documents are controlled and are reviewed in a timely manner as defined in policy and to meet the requirements of legislation.</p>	<p>controlled documents and reviewed in a timely manner to meet legislative requirements.</p> <p>90 days</p>
<p>Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	<p>PA Moderate</p>	<p>The process for documentation control is documented in policy but in practice this is not occurring. No policies or procedures have been reviewed since the previous audit.as per the timeframes documented on the policies and policy requirements. The human resource management manual has recently been reviewed for this audit but has not been signed off by the board.</p>	<p>There is currently no documented control system to manage policies and procedures No policies and procedures have been reviewed since 2017 and 2018. The quality manager has been appointed specifically to manage the payroll and to undertake the human resources manual review which has just been completed and is now awaiting approval from the board to be implemented.</p>	<p>To ensure there is a document control system that has been implemented. The system shall ensure policies and procedures are up-to-date, available and managed to preclude the use of obsolete documents.</p> <p>90 days</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line</p>	<p>PA Low</p>	<p>There is a four weekly cycle summer and winter menu. There was no evidence of a current menu that was reviewed within the past two years to verify that nutritional needs of the residents are being met. The menu in use was last reviewed by a dietitian in June 2017.</p>	<p>The menu in use was not reviewed by a dietitian within the past two years.</p>	<p>Provide evidence of a current menu review by a dietitian.</p>

with recognised nutritional guidelines appropriate to the consumer group.				180 days
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	<p>The RNs are responsible for developing the care plans including wound management plans. There was one trained interRAI assessor who was responsible for completing all interRAI assessments. The newly appointed enrolled nurse (EN) two weeks into the role was currently undergoing orientation and there are plans that the EN be enrolled in the interRAI training when able and when appropriate with the RN overseeing the process which could be beneficial. The health care assistants (HCAs) were responsible for completing wound care management and evaluation of wound care plans.</p>	<p>The was no evidence to demonstrate that the HCAs who were completing the wound care management and evaluation of wound care plans have received appropriate training in wound care management and evaluation.</p> <p>There was no evidence to demonstrate annual competency evaluation for the interRAI assessor.</p>	<p>Provide evidence that the HCAs who are responsible for completing wound care management have received appropriate training.</p> <p>Provide evidence that the interRAI assessor has completed the annual competency assessment.</p> <p>180 days</p>
<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</p>	PA Moderate	<p>The six-monthly interRAI reassessments are completed by the trained interRAI assessor with input from the nursing team and other allied health professional.</p>	<p>There were seven overdue interRAI reassessments. The overdue interval ranged from five to eight months.</p>	<p>Provide evidence that all interRAI reassessments are completed in a timely manner.</p>

for service delivery planning.				90 days
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	The wound management plans were being evaluated by the HCAs. However, the documentation did not evidence regular evaluation as per wound management plans.	The wound evaluation documentation was not completed consistently as per organisation's policies and procedures.	<p>Provide evidence of documented evaluation of wound care plans.</p> <p>180 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	The infection control programme is not documented, though there are policies and procedures to guide staff on infection control matters. There was a blank infection control programme annual review form sighted.	There was no evidence of a documented and annually reviewed infection control programme.	<p>Provide evidence of a documented infection control programme that is annually reviewed.</p> <p>180 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.