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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Howick Baptist Healthcare Limited
Premises audited:	Gulf Views Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 May 2021 End date: 1 June 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: 41

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

Gulf Views Rest Home provides residential care for up to 45 residents who require rest home level care. The facility is operated by Howick Baptist Healthcare (HBH) Limited who took over the service in 2020. Day to day operations are managed by a nurse manager with onsite support from a senior registered nurse team leader and others from the HBH group.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

There are no areas that required improvements identified at this audit. A continuous improvement rating was awarded for enhancement to quality and risk systems.

Consumer rights

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

Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents, and families is promoted and was confirmed to be effective. There are systems in place to ensure family/whānau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers in the community.

A complaints management process is clearly described in policy. Residents and relatives are advised on entry to the home about the processes for raising concerns or complaints and are given written information about their right to complain and where to access independent support and advocacy if required. The service is managing complaints fairly and openly.

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.

Business and quality and risk management plans include the (scope, direction, goals, values and mission statement) of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

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 review. Staffing levels and skill mix meet the changing needs of residents.

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

Residents' information is kept securely with all entries legible and designated.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

Needs Assessment Service Coordination (NASC) team assesses residents before entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurses (RNs).

Activities plans are completed by the RNs in consultation with the activities coordinators. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing, and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for. Snacks are provided to residents if needed.

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.

Waste and hazardous substances are managed safely. Staff have access to protective equipment and clothing and were observed using this. Chemicals are safely stored.

The building is in good order, has a current building warrant of fitness and meets the needs of residents. Electrical and medical equipment is tested as required. External areas are accessible, safe and provide shade and seating for residents. All areas of the home are well maintained and cleaned to a high standard. Laundry services are effective. This is managed by a designated laundry person seven days a week.

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

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. There have never been any restraints in use. On the days of audit 12 residents were using bed levers to assist with sitting up in bed. These were voluntary

enablers to promote the safety of residents and all had consented to their use. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are carried out as specified in the infection control programme.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	1	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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	All staff interviewed demonstrated knowledge and understanding of resident rights, obligations, and how to incorporate them as part of their everyday practice. Staff address residents with respect, knocking on doors, asking to enter rooms before entering, and providing residents with choices. Staff interviewed understood consumer rights and were aware of consumer rights legislation. Training about the Code of Health and Disability Services Consumers` Rights (the Code) has been provided.
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	Staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by competent residents or the enduring power of attorney (EPOA). The GPs make a clinically based decision on resuscitation authorisation of residents deemed not competent. Sampled files evidenced signed resuscitation decisions and advance directives by residents who are deemed competent. The senior RN team leader reported that residents were informed about advance directives from admission and on an ongoing basis. There were 22 residents with advance directives in place and those without were constantly encouraged to complete them. Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the

		service actively involves them in decisions that affect their family members' lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policies and procedures required that residents be informed of their right to access independent advocates. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were interviewed to confirm that they understand these rights and their entitlement to have the support person of their choice available if they choose.
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 were assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends were encouraged to visit or call. The facility has unrestricted visiting hours (unless restrictions are required due to the current Covid-19 pandemic national alert level). Family members interviewed stated they felt welcome when they visited and were comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints process and related information meets the requirements of Right 10 of the Code. Information about how to raise a complaint is on display in various locations throughout the home and is explained to residents and families on admission. Residents and families said they understood their right to complain and that they would not hesitate to do so if needed. The complaints register showed there had been two complaints received since the previous audit. The investigation and actions taken regarding these were documented with an outcome reached within a suitable timeframe. The nurse manager is responsible for complaint management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what they need to do if someone wants to complain. The provider advised there have been no known complaints to or investigations by external agencies such as the DHB or HDC.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Policies are in place to guide staff actions and ensure residents` rights are discussed. The Code was displayed throughout the facility and is available in Maori and English languages. Information about the Code is provided in the admission pack and included in the resident agreement. Family members

Consumers are informed of their rights.		and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process. The Nationwide Health and Disability Advocacy Service poster and pamphlets were also displayed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The residents' privacy and dignity were respected. This was confirmed in an interview with family/whānau and residents who expressed a high level of satisfaction with the service. Those interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice. There is an abuse and neglect policy available to staff and staff interviewed understood how to report such incidences if suspected or observed. The senior registered nurse Team Leader reported that any allegations of neglect, because of service delivery, were taken seriously and immediately followed up. The GP stated that there was no evidence of any abuse or neglect. Residents were able to move freely in and out of the facility and into the surrounding areas with no restrictions. The residents' preferred name is ascertained on admission, documented, and used by staff when addressing residents or family members. Individual values and wishes were considered. This was evident in resident records sampled. Spiritual needs were considered and catered for with church services provided monthly. Family/whānau interviewed described that staff were respectful and provides an environment that is family orientated.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The required policies on cultural appropriateness were documented. Policies refer to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural/spiritual needs. There was one resident who identified as Maori and had a Maori health care plan in place. In the interview conducted, family/whanau and resident confirmed that all their cultural needs were met. Special consideration to cultural needs is provided in the event of death. The required activities and blessings were conducted. All staff received cultural training annually.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural,	FA	Family members were interviewed to confirm that the resident's values and beliefs are actively recognised and well supported. This was confirmed by residents and through observations of interactions between staff and residents during the audit. Values and beliefs were discussed and incorporated into the care plan. The family members interviewed gave examples of being actively involved in any changes in routine for their family member. Staff interviewed were able to describe how each resident can make choices around activities of daily

spiritual values, and beliefs.		living and activities. Residents on the days of the audit were observed to actively engage in activities of their choice.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Gulf Views Rest Home has a policy on discrimination in place. This includes guidelines for staff regarding the prevention, identification, and management of discrimination, harassment, and exploitation. The senior RN team leader reported that the rights of the individuals were protected, and interventions occur to ensure a balance between the personal rights of the individual and others living and working in the facility. All family members interviewed reported that they believed their family members were always safe. Staff receive training on professional boundaries and code of conduct. The Code of Conduct is embedded in the employment agreement and is signed by each staff member on entry to the service. Situations that constitute misconduct are included in staff employment agreements. The senior RN team leader stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are policies and procedures to guide practice. There is a training programme implemented and staff interviewed described best practices based on policies and procedures. All family members interviewed stated that each resident received 'good care and support' with staff conscious of managing all residents' identified needs effectively. Consultation with key health professionals and services occurs as required for individual residents as sighted in resident records. There are about five GPs who are contracted to the service. The GP confirmed that they visit the facility at least weekly with each resident having a medical review at least monthly. The GP reiterated that there is good communication between medical staff and the staff in the facility and any instructions were carried out on time. The staff informs the general practitioner of any issues as they arise.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There was evidence that the service adheres to the practice of open disclosure. The senior RN team leader reported that all adverse events were managed in an open manner, and these were put in the context of quality improvement. This was evident in the incident forms completed and interviews with family members and residents. Access to interpreter services is available through the district health board if required. At the time of the audit, there were no residents who required an interpreter. Staff were observed to engage with

		residents in a way that involves them as much as possible. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ownership and the operations of Gulf Views Rest Home was taken over by Howick Baptist Healthcare Limited in late 2020, which is a charitable organisation. The organisation's vision, mission, values and annual goals are in the 2021 Quality Risk Management and Strategic Plan. This is reviewed regularly with the board who meet monthly with the chief executive officer (CEO) to consider all operational and financial business. Review of the reports to the board showed they are provided up to date information on occupancy rates, health and safety matters, audit outcomes, staffing information, financial reports, information about complaints and compliments received, resident care, quality and other service delivery matters. The CEO has been in the role for 17 years. There have been no changes to the scope or size of service since the takeover, and maximum occupancy remains at 45 residents. On the days of audit there were 41 residents. Thirty-nine of these were receiving rest home level care services under the age related care contract (ARCC) with the DHB. The service also has an agreement with the DHB to provide short term/respite care. One resident was on respite as a short-term occupant and one other resident was also short-term following hospital admission and funded by the DHB as primary options acute care (POAC). All residents had signed admission agreements. The nurse manager is a registered nurse who took up the manager's role in September 2020. This person was already employed as an enrolled nurse and then RN by HBH for 12 years and has extensive clinical skills and knowledge of the aged care sector. Their authority, accountability and responsibility for the provision of services is described in the position description attached to their employment agreement. Three of the total six registered nurses (including the NM) employed are maintaining competencies to undertake interRAI assessments.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and	FA	When the nurse manager is absent, the senior RN team leader carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by another nurse manager or a clinical leader from within the HBH group. All clinical leaders in the group are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.

effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The Howick Baptist Healthcare Quality and Risk management plan 2021 contains the organisations philosophy, values, mission, direction and goals written with specific measures and timeframes. A pre audit review of the sector standardised policies and procedures showed these are individualised and updated as required by key staff and the quality consultant. Review of the documented outcomes from internal audits and incidents reported since the previous provisional audit in August 2020 confirmed the quality and risk system as effective and compliant with this standard. Quality data is reported to the governing body each month and to all staff at their meetings. Gulf Views have logged 15 quality improvements since takeover. These include the NM and all staff having access to additional strategic and operational support via the wider HBH group, implementation of more robust and in-depth quality monitoring and reporting, enhanced staff communication, more streamlined staffing systems for rostering and leave applications, review and updating of clinical policy and procedures specifically, wound care planning, falls prevention and management, neurological assessments, infection control, manual handling, and environmental enhancements such as raised gardens, interior painting and décor, and replacement of chattels (linen, crockery, cutlery, cushions). A rating of continuous improvement is noted in criterion 1.2.3.6 for the positive impact that enhanced quality reporting has had on the timeliness and care of residents. Minutes of residents' meetings confirmed that residents are consulted about service delivery and are kept informed. Resident and relative satisfaction is formally surveyed annually and the results of these showed high satisfaction. The residents interviewed stated they are kept informed and are consulted about services in ways that they understand. The NM understands the requirements of the Health and Safety at Work Act 2015 including notifying staff when changes in practice or policies have occurred. The nominated health and safety staff representative has in depth understanding of the role, legislation and carries out frequent environmental safety inspections. There have been no notifications to Worksafe since the previous audit. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk. There is a current hazard register and all risks and health and safety protocols are discussed at staff meetings. This was confirmed by review of meeting minutes and interviews with the health and safety officer and management.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	An accident and incident policy is in place. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The NM receives and reviews all accident/incident forms, determines if an investigation is required and ensures corrective actions take place to prevent recurrence. A sample of incident/accident records and monthly summary sheets for 2020/2021 showed there was a coordinated approach to the management and review of the documented adverse events. Incidents and accidents are collated into graphs to compare the data month by month. All data is shared with staff at their meetings and the graphs are displayed. Any negative trends result in mitigating strategies being implemented in a timely manner. Residents' files evidenced communication with families following adverse events involving the resident, or any change to the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The NM demonstrated knowledge and understanding of essential notification reporting and stated that there had been no significant events at Gulf Views Rest Home that required notification to MOH and the DHB under section 31, or any other statutory agency, since the previous audit. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Staff are recruited and managed in accordance with good employer practices. Management and the human resources team from the HBH group understand and comply with current employment legislation. The skills and knowledge required for each role is documented in position descriptions and employment agreements. All staff interviewed confirmed they understood their roles, delegated authority and responsibilities. Each of the staff records sampled contained curriculum vitaes (CVs), educational achievements, evidence of referee and police checks, and current practising certificates for the registered nurses. New staff are oriented to organisational systems, quality and risk, the Code of Health and Disability Services Consumers' Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint minimisation, infection prevention and control and emergency situations. The eight staff records sampled contained copies of annual performance appraisals. Staff maintain knowledge and skills in emergency management, and competencies in medicine administration (for the staff who administer medicines).

		Three of the total six registered nurses employed (including the NM) are maintaining competencies to undertake interRAI assessments and all have current first aid certificates. In service education is provided monthly on a range of subject areas including infection control, resident rights, manual handling, health and safety. The service provider supports all staff to engage in ongoing training and education related to care of older people or the tasks they are employed for. Cooks, cleaners, laundry and all long-term care staff have completed qualifications in care of older people. Two of the nine care staff have obtained Level 4 of the national certificate, two have level 3, two are at level 2 and three are at level 1. The majority of care staff are long term employed and have previously completed the ACE programme.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The reviewed staffing policies adequately describe process for determining stall levels/skill mix and a staff to resident ratio protocol. Staff are rostered in ways that ensure there is a suitable mix of staff on site all times. Review of previous months and future planned rosters confirmed an appropriate number of staff on site for the needs of the current resident population. There are three care staff on duty each morning plus a short shift and one care staff member in the evenings (plus an RN). One care staff and one RN are rostered on each night. Two activities coordinators, a cook, laundry person and a cleaner are on site for a suitable number of hours Monday to Friday. Kitchen cleaning and laundry staff are also on site each Saturday and Sunday. Two RNs plus the nurse manager are on site during the day Monday and Friday. One RN is on site in the evenings and at night with the nurse manager on call, 24 hours a day and seven days a week. The residents interviewed said they were satisfied with the availability of staff. Family members said they had no concerns about staffing. All the staff interviewed expressed job satisfaction. Gulf Views has a high staff retention rate. A large percentage of staff have worked there for more than 20 years.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded,	FA	There is an electronic record management system in place. Residents' records are held both electronically and paper-based. The staff have individual passwords to the residents' records database, such as the medication management system and on the interRAI assessment tool. The visiting GPs and allied health providers also have access to the system which supports the

current, confidential, and accessible when required.		integration of residents' records. All hard copies were kept securely in the locked office. Hard copy archived records are stored safely and securely on-site. There is an effective system for retrieving both hard copies and electronically stored residents' records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The residents' entry to service policy is clearly outlined and explained to residents and their family representatives. The admission pack contains all the information about entry to the service. Assessments and entry screening processes were documented and communicated to the family/whānau of choice where appropriate, local communities, and referral agencies. Files sampled evidenced that all residents were assessed by specialists and confirmed the current level of care. Documentation regarding this was sighted. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family members interviewed confirmed that they received sufficient information regarding the services provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort /family member as appropriate. There is a documented process in place and open communication between all services, the resident, and the family. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. The service uses the DHB's (yellow envelope) system to facilitate the transfer of residents to and from acute care services. All referrals are recorded in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Gulf Views Rest Home has a safe system for medicine management using an electronic system that was observed on the day of audit. Staff have individual passwords to access the electronic medication management system. The RN was observed administering lunchtime medication and they demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Current medication administration competency forms were sighted.

		Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check the received medications against the prescriptions, and this was evidenced on the electronic records reviewed. There was no expired medication in the medication trolley and stock onsite. All eye drops were clearly dated when opened. The RN reported that unwanted and expired medication is returned to the pharmacy in a timely manner. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and room were within the recommended range. Temperature monitoring of the room where medicines are stored is also recorded. Three monthly medication reviews were completed consistently by the GP's. Standing orders are not used. Evaluation of PRN medication given was documented and evidenced on the electronic records reviewed. Appropriate processes for medicines self-administration were in place to ensure this was managed in a safe manner. One rest home resident self-administered medication. When interviewed they confirmed they inform the RN when medications are taken. Staff interviewed confirmed this. The residents' competency documentation was completed and sighted. There is an implemented process for comprehensive analysis of any medication errors. One medication error has occurred since the last audit, this was reviewed, learnings sought, corrective actions implemented and signed off when completed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is run by the kitchen manager who is assisted by cooks and catering assistants. The kitchen service complies with current food safety legislation and guidelines. There is an approved food control plan for the service which expires 21 June 2021. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian on 30 March 2021. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weight was monitored regularly, and supplements were provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all

		containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of fridges and freezers are maintained, The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The senior RN team leader reported that all residents who were declined entry were noted down. Further explained that when a resident is declined entry, family/whanau and the resident were informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider,
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents' level of care is identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' long-term care plans and interRAI were completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the family, residents, and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional, fall continence, and skin and pressure risk assessments). The RNs utilise standardised risk assessment tools on admission. In interviews conducted, family member representatives and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The outcome findings from interRAI assessments and input from residents and/or family/whanau inform the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident-focused and individualised. Short-term care plans sampled contained a problem list, goal, intervention, evaluation, and completion date, and were appropriate for the identified problem. Behaviour management plans were implemented as required. The care plans sighted were specific. A Maori health care plan prepared for a resident who identified as Maori was in place. Family and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, occupational therapists, district nurses, dietitians, and GP.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. Wound assessment and wound care plans were being completed and evidence of this was sighted in files sampled. The senior RN team leader reported that the GPs' medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person-centred. This was confirmed by the GP during the interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and following 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	Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by two activities coordinators with support from an occupational therapist from a sister facility. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A special interests lifestyle questionnaire is completed for each resident within two weeks of admission in consultation with the family. The activities coordinator attends the Monday morning handover for an update on the residents' condition from the nursing team. The activity programme is formulated by the activities staff. The activities are varied and appropriate for residents assessed as requiring a rest home level of care. Residents' activities care plans were evaluated along with long-term care plans and interRAI assessments. Monthly minutes of residents' committee meetings and all residents' (Busy Bee) meeting conducted every two months were sighted. The activities coordinator reported that plans to incorporate the Eden model into the activities programme were currently underway. Activity progress notes and activity individual participation records are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants were reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response about desired outcomes and goals, occur every six months or sooner if residents' needs change. The evaluations are carried out by the RNs in conjunction with family, residents, GPs', and

		specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed regularly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family members were included and informed of all changes.
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 and family/whanau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GPs and the nursing team refers to specialist service providers and the DHB. Referrals are followed up regularly by the GPs. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies and procedures related to waste are documented and comply with legislation and local authority by laws. Staff interviews, observations and visual inspection of all areas revealed that there are no hazardous substances stored on site. Household and biological waste is disposed of appropriately. A sharps collection box is stored securely. All body waste is handled using standard and universal precautions. Incontinence products are placed in an outside receptacle for weekly collection and disposal. There is minimal food waste and the management of this and/or other organic waste complies with environmental guidelines. A designated bin for infected waste is stored outside and staff understood when to use it. Staff were observed to be using hair nets, aprons and gloves when engaging in food handling, personal cares, cleaning or laundry tasks.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. A maintenance person ensures a proactive and reactive maintenance programme is in place and buildings, plant and equipment are maintained to a high standard. The testing and tagging of equipment and calibration of biomedical equipment occurred in February 2021 and July 2021 respectively. A current building warrant of fitness is on display which expires 04 March 2022. Passageways are wide enough with hand rails to allow residents and staff to pass easily. Bedrooms are large enough to store mobility aids. The external areas available for residents are routinely maintained, safe and are appropriate. Residents are protected from risks associated with being outside. This was confirmed by

		visual inspection, documents reviewed, staff and resident and relatives interviewed. Staff confirmed they know the process they should follow if any repairs/maintenance is required and said that requests are appropriately actioned. Residents interviewed confirmed they can move freely around the home and that the facility meets their needs.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Each of the 45 bedrooms have hand basins. Five bedrooms have their own ensuite bathrooms, 37 have toilets and the other three bedrooms have easy access to communal bathrooms which are within close walking distance. None of the bedrooms have premium charges attached to them. The residents interviewed were happy with the toilet and shower facilities. Hot water temperatures are tested monthly and records show steady safe temperatures (45 degrees or lower) delivered at the taps accessed by residents. There was evidence that a plumbing firm adjusted the tempering valves when hot water temperatures rose to over 47 degrees earlier this year.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident bedrooms are designated for a sole occupant. These are sufficiently sized to accommodate the use of mobility equipment along with two staff and a resident at the same time. Residents are encouraged to bring in their own furniture. The rooms inspected were personalised with a mix of the resident's furniture and what is provided by the home, televisions, radios, storage and armchairs. These were individually decorated. The resident's interviewed expressed satisfaction with their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Residents have a choice of areas for visiting, activities, and relaxing. The dining room is large, located next to the kitchen and is easily accessible for all residents. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents and families were very happy with the communal areas and the layout of the home.
Standard 1.4.6: Cleaning And Laundry Services	FA	Resident's personal laundry is washed and dried on site. Towels/ bed linen and other bulk laundry is sent to be laundered by Howick Baptist Hospital nearby. Laundry staff attend regular education and

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		demonstrated good knowledge of safe and hygienic laundry processes. Residents and families reported the laundry was well managed and their clothes are returned in a timely manner. There are dedicated cleaners on site seven days a week. Interviews and staff records showed that all have attended training in safe handling of chemicals and other topics. Cleaning chemicals are stored in lockable cupboards. All chemicals were in appropriately labelled containers. Residents and family said the facility is cleaned to a high standard which was confirmed by visual inspection during the audit. Effectiveness of the cleaning and laundry processes is monitored through the internal audit programme. Where these audits identified the need for improvement, corrective actions were implemented and then reassessed to test that improvement had occurred.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A facility evacuation plan was approved by the New Zealand Fire Service in 1994. The most recent planned fire drill occurred on 27 April 2021. The results of trial evacuations are recorded to show the time taken to clear the building and any issues that arose, of which there had been none. A hard-wired fire suppression system (sprinklers and smoke detectors) have been installed, the building contains fire cells and exit signs are clearly displayed. All required firefighting equipment is checked monthly by an external contractor. Staff confirmed their awareness of emergency procedures. They complete competency questionnaires prior to their annual performance appraisal. The orientation programme includes fire and security training. There is always at least one staff member on duty with a current first aid certificate. A civil defence plan is in place. The civil defence kit inspected on site contains essential emergency supplies and equipment such as portable torches and batteries and is checked regularly. There is sufficient water and food available for the needs of 45 residents and staff for three to five days. This adheres to the Ministry of Civil Defence and Emergency Management recommendations for emergency water storage in the Auckland region. Gas barbeques are stored ready for cooking in the event of power outage. The call bell system is functional, and staff were observed to respond to the bell immediately. Residents and family members said staff were always attentive and responsive. The external doors are secured at dusk and a bell at the front door for visitors to ring after hours. A security firm monitors the facility three times during the night. Sensor lights are situated around the exterior of the building.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All areas of the home have sufficient natural light. Each bedroom has large opening doors and windows and many have ranch slider doors to the outside with security latches attached. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Heating is provided by central heating ducted in the ceilings. Heat pumps are provided in the dining and lounge areas to cool the air in summer. There are surplus quilts and blankets for additional warmth in the event of an electrical power outage. The facility, both internally and externally, including the grounds are smoke free. The residents interviewed confirmed the temperature in the home is comfortable all year round. There have been no complaints or issues raised about temperatures in the resident's meetings or in the building maintenance logs.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Gulf Views Rest Home has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control plan and manual, with input from the quality and infection control coordinator. The infection control programme and manual are reviewed annually, this was verified in the documents reviewed. The NM is the designated IPC coordinator, whose role and responsibilities are defined in the infection prevention and control policy and programme. The IPC coordinator is supported by the RNs in monitoring infections within the facility. IPC matters, including surveillance results, are reported monthly to the general manager via the IPC and health and safety committee, which includes the nurse manager, RN, the health and safety officer, and representatives from food services and household. IPC outcomes are tabled quarterly at the clinical quality improvement committee meeting. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The COVID-19 infection control procedures were in place including all visitors signing in and scanning COVID 19 QR Code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The staff interviewed understood these responsibilities. Residents and staff were offered influenza vaccinations through their GPs and vaccination consent forms were sighted in documents reviewed.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. They have attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the Howick Baptist Hospital, the community laboratory, the GP, DHB and regional public health, as required. The

to implement the infection control programme and meet the needs of the organisation.		coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2021 and include appropriate referencing and document control. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified infection prevention and control consultant and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained and was sighted in records reviewed. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. Appropriate education was provided to all staff and residents during the COVID-19 lockdown situations. All RNs and care staff have received additional online training on COVID-19 for nursing professionals, advanced infection control for COVID-19 and donning and doffing of personal protective equipment. Current information pertaining to COVID-19 pandemic infection control was posted on notice boards throughout the facility and information pamphlets were available at the reception. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, how to sneeze and cough, advice about remaining in their room if they are unwell, increasing fluids during hot weather and for those who are at risk of urinary tract infections. Evidence

		of this was sighted in the reviewed residents' records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. 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, at staff handovers and notice board in nurse's station. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the IPC/health and safety committee and all staff. The statistics have provided assurance that infection rates in the facility remain low. Regular infection control audits were conducted including hand washing, kitchen, audit, food storage and environmental hygiene. Corrective actions were implemented where required. A targeted programme that was commenced in 2017 to reduce urinary tract infections is ongoing and is effective. The programme includes staff education, encouraging increased fluid intake for the identified at risk residents, where it is not medically contra- indicated, and maintaining regular monitoring using the fluid balance charts. Urinary tract infection rates continue to be monitored and reported monthly. The surveillance data demonstrated continued low rates compared to 2017 and stable rates in 2020 – 2021.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Gulf Views has a philosophy and practice of no restraint. Restraint has never been used and the intention is not to use restraint. The restraint coordinator is one of the RNs and this person demonstrated good knowledge relating to restraint. The restraint coordinator and the NM discussed options and resources available should a resident require interim support. These included use of low beds to prevent injury from falls out of bed, and extra staff to 'special' /supervise an at risk resident. The restraint minimisation and safe practice policy clearly defines the difference between restraint and enablers, and forms and processes such as a restraint register are available if a restraint is required.. Twelve residents had bed levers attached to their beds to support them with sitting up and getting in

		and out of bed. Documentation for this had been completed. The sample of staff records reviewed showed that training in the prevention of restraint use, managing falls and challenging behaviours is occurring regularly.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The quality and risk management systems have been significantly updated to match the systems in use across all Howick Baptist Senior Living facilities. The organisation has conducted an extensive review of the policy and procedure set, updated these to current best practice and is rolling them out across their three facilities including Gulf Views. Clinical staff are receiving extensive mentoring, supervision and training to understand and incorporate new clinical procedures into their practice. Gulf Views has also implemented the HBH system for collecting and analysing quality data. This allows more efficient and effective identification of at risk residents, which speeds up the communication/reporting and risk mitigation stages. Additionally, Gulf Views is now able to benchmark and compare their quality data to the data coming from the two rest home services within the HBH	Having fully attained the criterion the service can in addition to this clearly demonstrate that improvements in the quality system have occurred in ways that benefit resident care and staff competence. This includes updating policies and procedures to reflect best practice, implementing new methods for collecting quality data, and conducting analysis and review of the data. Meeting minutes, resident records and GP, staff and management interviews confirmed that this has resulted in quicker and more detailed identification of at risk residents and implementation of strategies to reduce, isolate or minimise the risks they are exposed to. Furthermore Gulf Views is for the first time comparing their quality data with that from other similar sized rest home services, so they can measure and track their service delivery and operations.

		group, and be part of the external benchmarking provided by QPS Ltd which considers rest home care in New Zealand and Australia. The level of reporting at staff meetings and to the wider group contains more detail and specific measurements.	

End of the report.