

T M & D L Beer Holdings Limited - Cardrona Rest Home & Hospital

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 BSI Group New Zealand Ltd, 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: TM & DL Beer Holdings Limited

Premises audited: Cardrona Rest Home & Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 27 May 2021 End date: 28 May 2021

Proposed changes to current services (if any): Two rooms have been assessed as suitable for rest home or hospital level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 33



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
Yellow	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
Red	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

Cardrona Rest Home and Hospital is privately owned and operated. The service is currently certified to provide care for up to 35 residents requiring hospital or rest home level care. On the day of the audit, there were 33 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management. The service is overseen by a general manager with additional managerial and clinical support provided by a clinical operations manager/registered nurse. Residents, family and the GP interviewed spoke positively about the service provided.

In addition to completing a full certification audit, this audit determined the suitability of two additional dual purpose (rest home or hospital level) beds.

One area for improvement identified is related to cultural considerations for Māori residents.

A rating of continuous improvement was awarded for good practice.

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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Information about services provided is readily available to residents and families. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Examples of good practice are evident. Residents are encouraged to maintain links with the community. Residents and family reported communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned and coordinated and are appropriate to the needs of the residents. Both the general manager and the clinical operations manager are responsible for the day-to-day operations of the care facility. The clinical operations manager is supported in her absence by a registered nurse and team of care staff. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place

for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

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.
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The clinical operations manager/registered nurse takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed they are involved in the care planning and review process. Each resident has access to individual and group activities programmes. The group programme is varied and interesting. Medicines are stored and managed appropriately. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on site and the menu has been reviewed by a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Rooms are individualised. There are several lounges and a spacious dining area. There are adequate toilets and showers. The internal areas are ventilated and heated. There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are safe and easily accessible. Cleaning services are well monitored through the internal auditing system. Laundry is completed on site by dedicated laundry staff. Two additional single bedrooms have been added since the previous audit. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency for residents and staff.

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 and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is the clinical operations manager who is responsible for ensuring restraint management processes are followed. On the day of audit there were no residents using either restraints or enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	1	43	0	1	0	0	0
Criteria	1	91	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. Two managers (one general manager (GM) and one clinical operations manager/registered nurse (COM/RN)); and ten staff (three caregivers, one staff RN, one maintenance, two activities coordinators, one cook, one laundry and one cleaner) interviewed, confirmed their understanding of the Code and were able to provide examples of how the Code is applicable to their job role and responsibilities. Staff receive training about the Code during their induction to the service. This training continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files sampled (three rest home - including one ACC resident and three hospital - including one respite resident) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. Five of six resident files sampled had a signed admission agreement (one newly admitted resident’s agreement was at the lawyers). Consents were signed.</p>

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service and continues as a regular in-service topic.</p> <p>Residents and family interviewed confirmed that they are aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with the rest home level residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Local entertainers regularly visit the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A register of all complaints received is maintained. One complaint was lodged in 2020 and one in 2021 (year to date).</p> <p>Both complaints reflected evidence of acknowledgement, an investigation and communication with the complainant within the timeframes determined by HDC. Staff are kept informed in meetings, evidenced in staff meeting minutes. Both complaints have been documented as resolved to the complainant's satisfaction. Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they may have had were addressed promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to new residents and their families. The COM, GM and/or RN staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during monthly resident meetings, led by activities staff. All eleven residents (five rest home, six hospital) and four family (two rest home, two hospital) interviewed, reported that they had been provided with information relating to their rights.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The residents' personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors.</p> <p>The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible.</p> <p>There are three rooms that are being used as double rooms. All three rooms have privacy curtains and a call bell next to each bed.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>PA Low</p>	<p>A cultural safety policy is documented for the service. As per the cultural policy, the individual needs of residents are assessed on admission and as required and that all information regarding cultural (and spiritual) beliefs are identified in the care plan. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. Resident rooms are blessed following a death.</p> <p>There were two residents living at the facility that identified as Māori during the audit. One family member/whānau and resident were interviewed and stated that their needs as Māori were being met by staff. The resident stated they were very happy living at Cardrona Rest Home.</p> <p>Both files of residents who identify as Māori were reviewed. Neither file identified the resident's ethnicity in their care plan. And the resident interviewed, who identified specific values relating to their culture during the interview around the importance of whānau did not have this documented in their care plan.</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,</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans although was missing in one file reviewed of a Māori resident (link 1.1.4.3). Information is collected through the resident and their family/whānau to identify specific cultural values and identify ways to apply these principles. Residents and family interviewed confirmed they are involved in developing the resident's plan of care.</p>

and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Good practice was evident. A registered nurse is on site 24 hours a day, 7 days a week. A GP visits the facility once a fortnight. Residents are reviewed by the GP every three months at a minimum.</p> <p>The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Support is also provided through Hospice New Zealand. Physiotherapy services are available on an as needed basis through a local provider.</p> <p>The clinical operations manager has completed a postgraduate diploma in health science advanced nursing, specialising in common and chronic health conditions (June 2016). She was approved to prescribe in primary health and speciality teams in July 2019. Also, of a high standard are the three-monthly resident reviews that involve family and the notable decrease in residents' falls over the past 12 months.</p> <p>Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed very satisfied residents and families.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. A family communication sheet is held in the front of the residents' files. Families are contacted three-monthly in order to be kept informed (link CI 1.1.8.1). Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the Citizens' Advice Bureau. Families and staff are utilised in the first instance. There were no residents at the time of the audit who were unable to</p>

		<p>speak fluent English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Cardrona Rest Home provides care for up to 35 residents at rest home and hospital (geriatric and medical) levels of care. Twelve beds are designated as dual purpose. During the audit, there were 25 rest home level residents and 8 hospital residents. One resident (hospital) was on respite and one resident (rest home) was funded by ACC. All remaining residents were on the age-related residential care contract (ARCC). Two additional (single) residents' rooms were assessed as suitable for either rest home or hospital level of care (link 1.4.2).</p> <p>An annual business plan includes an aim, strategy and measurable goals. Business goals are regularly reviewed with the GM and COM.</p> <p>The general manager (GM) was employed in February 2015 and is responsible for all non-clinical related activities for two aged care facilities with the same ownership. Previous experience was held with the Ministry of Primary Industries. The GM is on site at Cardrona Rest Home three days per week, alternating with the clinical operations manager (COM). The COM/RN works at this site two days a week (and at another site owned by the same owners three days a week, again alternating with the GM). She has worked in the aged care sector for approximately 20 years, holds a postgraduate qualification in Advanced Nursing and is approved to prescribe in primary health and specialty teams (link CI 1.1.8.1).</p> <p>Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the absence of the COM/RN, the second in charge (2IC) RN assumes clinical responsibilities. All non-clinical and administrative responsibilities are delegated to the GM. The COM is responsible for administrative responsibilities in the absence of the GM. The business owner (non-clinical) is also available for support in the absence of the GM.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the GM, COM, and staff confirmed their understanding of the quality and risk management systems that have been put into place.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies (sighted).</p> <p>Quality data collected is collated, trended and analysed using a run chart methodology. Quality data is regularly communicated to staff via monthly staff meetings and through the use of graphs that are posted each month in the staffroom. The run charts used to display trends (eg, falls) provides staff with meaningful information (link CI 1.1.8.1).</p> <p>An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. There is evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions. A quality improvement register is maintained that keeps a running tally of quality initiatives through the use of a quality improvement register (QIR) (eg, remodel of a bedroom and TV lounge into two bedrooms and bathrooms (links 1.2.1, 1.4.2); upgrade to the call bell system; upgrade to the payroll system). Staff are informed of results, evidenced in the monthly staff meeting minutes. Staff sign and read the meeting minutes.</p> <p>A health and safety programme is in place. An interview with the health and safety officer (COM) and review of health and safety documentation confirmed that robust health and safety processes are being implemented. External contractors are orientated to the facility's health and safety programme with health and safety permits renewed each year. The hazard register is regularly reviewed (1 September 2020). Health and safety checks take place monthly.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring for those residents at high risk of falling, and the identification and meeting of individual resident needs. Falls have reduced significantly since May 2020 (link CI 1.1.8.1).</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</p>	<p>FA</p>	<p>An accidents and incidents reporting policy is in place. Ten accident/incident forms were reviewed (nine falls with neurological observations completed for unwitnessed falls, and one skin tear). There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by an RN.</p> <p>Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events (link CI 1.1.8.1).</p> <p>The GM and COM are aware of the requirement to notify relevant authorities in relation to essential notifications with examples provided (three stage three pressure injuries, one theft, one resident who</p>

an open manner.		absconded).
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in six staff files randomly selected for review (one RN, one cook, four caregivers).</p> <p>Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all six staff files. Staff have also signed that they have read the staff induction handbook. Staff appraisals are completed annually.</p> <p>An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including (but not limited to): nurse specialists, Age Concern and the Health and Disability Advocacy Service. Three RNs (including the COM) have completed interRAI training. There is a minimum of a first aid qualified staff on duty 24 hours a day, seven days a week and while out on outings with residents. Out of a total of thirteen caregivers, four have achieved a level four Careerforce qualification in health and well-being and three have achieved a level three qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The GM and COM are available Monday – Friday. The GM is on site three days a week and the COM is on site the remaining two days a week.</p> <p>The facility had 33 residents at the time of the audit (25 rest home and 8 hospital) and is staffed with one staff RN on each shift, seven days a week. Three caregivers are rostered on the AM shift (two long and one short (0800 – 1300). Three caregivers are rostered on the PM shift (two long and one short (1600 – 2100) and two caregivers are rostered on the night shift.</p> <p>The proposed increase in two dual-purpose beds will result in adding one short shift caregiver on the AM shift and PM shift with no change in staffing for the night shift. The GM stated that she would need to hire two additional staff and already has two applicants in mind from the local community.</p> <p>Extra staff can be called on for increased resident requirements. Activities staff are rostered seven days a week (five hours Monday – Friday and three hours on Saturday/Sunday). There are separate domestic staff who are responsible for cleaning (five days a week) and laundry services (seven days a week).</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</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>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed and signed by the RN/carer and include their designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Prior to entry all potential residents have a needs assessment completed by the needs assessment and coordination service to assess suitability for entry to the service. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical operations manager/registered nurse screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the general manager and the clinical operations manager. The admission agreement form in use aligns with the requirements of the ARRC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. A transfer form accompanies residents to receiving facilities. Relatives are notified if transfers occur.</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</p>	FA	<p>Twelve medication charts were reviewed (six hospital - including one respite resident and six rest home - including one ACC resident). There are policies available for safe medicine management that meet legislative requirements. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident's medication three-monthly, and all allergies were noted.</p> <p>All clinical staff who administer medications (registered nurses only) have been assessed for competency on an annual basis. Caregivers who check medications with the registered nurses are competency tested annually. Education around safe medication administration has been provided. Staff were observed to be</p>

<p>practice guidelines.</p>		<p>safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses an electronic charting system and robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>No standing orders are used. The clinical operations manager is a nurse prescriber. There were three rest home residents self-medicating ointments or inhalers on the day of audit and all required documentation had been completed.</p> <p>The medication fridge and medication room temperatures are recorded regularly, and these are within acceptable ranges.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Cardrona are prepared and cooked on site. There is a food services manual in place to guide staff. The food service menu was audited by a dietitian May 2021. The verified food control plan expires 9 August 2022. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. The cook is aware of any residents with weight loss and provides non-prescribed high protein supplements as instructed by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met.</p> <p>The chef meets with residents during meal times, observes and receives verbal feedback on the menu. The chef has strong links with the RN team where she monitors resident's meal consumption, records food wastage and reports to the RN about those residents of concern.</p> <p>Meals are plated and served from the kitchen to the rest home and hospital residents in the dining room. A tray service is available for those residents who wish to have their meals in their rooms. Staff were observed assisting residents with their meals and drinks.</p> <p>The three freezers and four fridges' temperatures are checked daily with evidence of corrective actions taken as needed (recordings sighted). End-cooked food temperatures are recorded daily. Dry goods are stored adequately. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed their food safety course.</p> <p>There are specialised crockery, plates, mugs and utensils to promote resident independence with meals.</p> <p>Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food service provided.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative, where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six-monthly or when there was a change to a resident's health condition. InterRAI assessments have been completed at least six-monthly for all long term ARRC residents. Care plans sampled were developed on the basis of these assessments. Full nursing, dietary, fall risks and pressure area risk assessment were undertaken for all residents.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The long-term care plans reviewed described the support required to meet the resident's goals and needs. The care plans sampled identified allied health involvement. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. The care plans are person centred and include physical, spiritual, psychosocial and social needs. Short-term care plans are used for changes in health status including infections, use of mobility scooter, anxiety/restlessness and wounds. Staff interviewed reported they found the plans easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	FA	RNs and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical and dressing supplies. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Palliative care support is available

<p>desired outcomes.</p>		<p>through the hospice and palliative nurse's visit by referral or request.</p> <p>Wound assessment, monitoring, wound management plans and evaluations (with appropriate timeframes) are in place for residents with wounds (one skin tear, three skin lesions and one resident with seven venous wounds). There were no pressure injuries at time of audit. The RNs have access to specialist nursing wound care management advice through the district nursing service and DHB wound care nurse specialist.</p> <p>Resident weight is recorded on admission and monitored monthly or more frequently. The RNs and the cook work collaboratively to manage resident healthy weights. GP notification, dietitian referral or speech language referral for swallowing difficulties are actioned as appropriate.</p> <p>Monitoring forms used included: Pain, behaviour, blood pressure, pulse, temperature, wound, weight and blood glucose levels.</p> <p>Interviews with RNs and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions document interventions in sufficient detail to meet the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Two activity coordinators are employed and between them cover Monday to Friday, six hours per day and Saturday and Sunday, three hours per day. Each resident has an individual activities assessment on admission. An individual activities plan is developed for each resident by the lead activities coordinator in consultation with the resident, families and RNs.</p> <p>The activity programme is driven by resident choice and planned monthly. Each resident is free to choose whether they wish to participate in the group activities programme or their own planned personal programme. Participation is monitored and documented. The activities coordinators network with and attend monthly sessions with the Waikato Diversional Therapy Support Group and there are strong links with community. The home has a van and regular outings occur. Both coordinators have a current first aid certificate. Rest home and hospital residents join together for the activity programme which is designed to meet the recreational needs of all residents. Young people with disabilities are able to participate in a range of activities to support their interests, hobbies and life-long goals. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. One-on-one time is spent with residents who choose not to participate or are unable to join in the activity programme. The monthly programme included: live entertainment once or twice a week, visits by pets each week, younger children coming to the home, a school orchestra, a school kapa haka group – thoroughly enjoyed by residents - exercises, ball games, reading, church services, library visit and pamper days which included foot spas.</p> <p>All long-term resident files sampled have a recent activity plan. The activity coordinators are involved in the resident review and this is appraised at least three-monthly when the care plan is evaluated or when there is a significant change. Monthly and six-monthly notes are recorded in the residents' files.</p>

		Residents and relatives interviewed are satisfied with the current activity programme and the one-on-one companionship provided to the residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files sampled demonstrated that the long-term care plan has been evaluated against current goals. Since 2019 these evaluations have been undertaken routinely three-monthly instead of six-monthly. This three-monthly evaluation includes involvement of the family where possible and where progress is different from expected, the service responds by initiating changes to the care plan. There was at least a three-monthly review by the GP. Alternate evaluations (i.e., six monthly) have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
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	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The service provided examples of where a resident's condition had changed, and the resident was reassessed for a higher or a different level of care.
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	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.

during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness which expires on 9 December 2021. There is a maintenance person employed part-time to address the reactive and planned maintenance programme. All reactive maintenance had been completed. All medical and electrical equipment was recently serviced and/or calibrated (May 2021). Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment (including personal equipment to support individual needs) to safely deliver the cares as outlined in the resident care plans for all people receiving services.</p> <p>Recent reconfiguration of a second TV lounge and a large dysfunctional bathroom has resulted in two additional single, dual purpose bedrooms and a functional bathroom with shower, toilet and handbasin. There remains lounge space in the form of a conservatory, activities lounge and a TV lounge. There is also a large and small dining room.</p> <p>The facility has been working through rooms systematically as they have become free to repaint/decorate. This includes ensuring double rooms have appropriate privacy equipment and storage appropriate for infection control.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have shared ensuites and other residents share communal toilets and showers close to their rooms. Residents interviewed confirmed their privacy is assured when staff are providing assistance with personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided</p>	FA	<p>There are six double rooms within the facility. All other bedrooms are single. In the double rooms, there are privacy curtains. In the lower level, there are twelve single rooms, six share an ensuite between two rooms. All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and</p>

<p>with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</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 are several lounges and a large and small dining area. The lounges and dining room are accessible and accommodate the equipment required for the residents. The lounges and dining areas are large enough to cater for activities. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit.</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 and cleaning is completed on site by dedicated staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness and the laundry services provided.</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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including food, water and blankets meeting requirements determined by the Waikato DHB. A gas barbeque is available. Civil defence, first aid and pandemic supplies are checked monthly.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. The double rooms have a call bell accessible for each resident.</p> <p>There is a minimum of one staff available 24 hours a day, 7 days a week with a current first aid/CPR</p>

		certificate. Activities staff who accompany residents on outings also hold a current first aid/CPR certificate.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	Cardrona Rest Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical operations manager/registered nurse is the designated infection control coordinator with support from all staff as members of the infection control team. Infection control is discussed at all staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed biannually with an additional update of policies relating to Covid in April 2021.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The clinical operations manager is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the local laboratory infection control team and IC nurse specialist at the DHB, they also subscribe to an external advisory service (Bug Control). Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p>	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and

<p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred along with additional toolbox and handover infection control educational sessions over the past year. The infection control coordinator has completed education in infection control as part of her postgraduate studies and has also completed online infection control training. There have been no outbreaks at the home. Information is provided to residents and visitors that is appropriate to their needs.</p>
<p>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.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Cardona's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at all staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical operations manager/registered nurse. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The COM is the restraint coordinator. No residents were using restraints or enablers at the time of the audit. Restraint processes are in place if restraint is necessary. Staff receive regular training around restraint minimisation that begins during their induction to the service and is repeated annually.</p>

actively minimised.		
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.4.3</p> <p>The organisation plans to ensure Māori receive services commensurate with their needs.</p>	PA Low	<p>Policies and procedures are in place to address cultural safety. Staff attend cultural training. Two residents identified as Māori at the time of the audit and neither resident’s ethnicity was identified in their care plans. One resident and their whānau were interviewed. This resident’s care plan did not address ethnicity or specific Māori values that were identified during the interview.</p>	<p>The two Māori residents living at the facility did not have their ethnicity identified in their care plans. One Māori resident interviewed indicated specific values to the auditor. These values around the importance of whānau were not documented in the resident’s care plan.</p>	<p>Ensure residents who identify as Māori have this identified in their care plan, and that the care plan addresses any additional cultural values and beliefs held by the resident.</p> <p>90 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, 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
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Examples of good practice were evident during the audit. In particular, the clinical operations manager is approved to prescribe in primary health and specialty teams (July 2019), which has improved the overall timeliness and efficiency when dealing with unwell residents; families are provided with a comprehensive review of the resident on a three-monthly basis; and the rate of residents' falls have reduced significantly over the past 12 months.</p>	<p>The achievement of the rating that the service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service providers. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Examples include the following:</p> <ul style="list-style-type: none"> i) A registered nurse prescribing policy and associated guidelines have been developed and implemented. This has resulted in the timeliness of care for residents outside of the doctor's availability, the prescribed care is more specific and individualised with the resident well known to the prescriber (clinical operations manager). Standing orders previously in place have been removed. ii) Families/next of kin (NOK) are provided with a three-monthly

			<p>review via telephone communications relating to the resident's condition (including but not limited to nutrition, pain, activities, mobility, activities of daily living, continence, behaviour). This form is signed and dated with comments by family and the clinical operations manager with follow-up actions documented (if any). Families interviewed remarked that this initiative is very beneficial, keeps them better informed and that they appreciate this initiative.</p> <p>iii) Resident falls have reduced over the past year with falls peaking in May 2020 (36 residents' falls/1000 bed nights) to as low as four in September 2021. The COM reported that this is the result of increase staff awareness of residents who are at risk of falling, utilising sensor mats, and implementing regular toileting and checks (intentional rounding) of those residents at risk. Graphs are posted in the staffroom and care staff interviewed are very aware of which residents are at risk of falling, and the initiatives that have been implemented to help reduce the frequency of falls.</p>
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End of the report.