

Karaka Court Limited - Woodlands of Feilding

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:	Karaka Court Limited
Premises audited:	Woodlands Of Feilding
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 July 2021 End date: 2 July 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	69

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

Woodlands of Feilding provides rest home and hospital level care for up to 80 residents. On the days of audit there were 69 residents. The home sits in the grounds of Woodlands retirement village which is managed and run independently to the home.

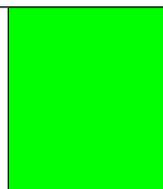
The service is managed by an appropriately qualified and experienced clinical nurse manager who is supported by a clinical nurse leader. The company director also plays a role in management.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner. The residents and relatives interviewed spoke positively about the care and support provided.

This audit has identified improvements required around staff training, risk management, service provision requirements and care planning.

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.

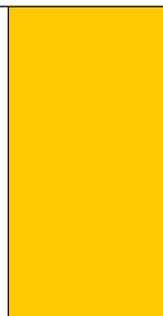


Standards applicable to this service fully attained.

Woodlands of Feilding practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends can visit at any time and ongoing involvement with community activity is supported. Residents and relatives are informed about the complaints process and complaints are well managed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation has an annual business and quality plan in place with annual quality objectives. Quality information is reported to two monthly quality/risk staff meetings. An annual survey and two monthly resident meetings provide residents and families with an opportunity for feedback about the service. The service has policies/procedures to provide rest home and hospital level of care.

There is an orientation and training programme in place. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

The diversional therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on food services.

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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Appropriate policies and product safety charts are available. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. All rooms are single with full ensuite facilities. There are toilets situated close to communal areas. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available. Large open plan lounge and dining areas are centrally located on each wing with smaller seating areas provided in the large foyer and smaller rooms including the chapel and library for residents and relatives to enjoy.

Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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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Woodlands of Feilding has restraint minimisation and safe practice policies and procedures in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. Staff receive education and training in restraint minimisation and challenging behaviour management. On the day of audit, there were six residents with restraint and 26 residents with an enabler. Enabler use is voluntary. A register is maintained by the restraint coordinator/registered nurse (RN). Residents using restraints are reviewed a minimum of six-monthly by the clinical manager, RNs and GP.

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 programme is appropriate for the size and complexity of the service. The infection control coordinator is responsible for coordinating and providing education and training for all staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. In practice, a very active ongoing focus on hand hygiene and outbreak management was maintained.

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	46	0	1	3	0	0
Criteria	0	97	0	1	3	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>Woodlands of Feilding practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Posters of the Code are displayed in the facility. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service. Interviews with eight care staff (four caregivers, four registered nurses (RN) and one diversional therapist) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs for written general consents including outings and indemnity. Separate consent forms were signed by the resident or EPOA for flu and Covid vaccines. Cardiopulmonary resuscitation status has been appropriately signed in the nine resident files reviewed (five hospital and four rest home). Copies of enduring power of attorney where known were included in the resident file.</p> <p>Registered nurses and caregivers interviewed confirmed verbal consent is obtained when delivering care. Family members confirmed they were involved in decisions that affect their relative's lives. All</p>

		resident files contained a signed admission agreement.
<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	Residents and families are provided with information about the Nationwide Health and Disability Advocacy Service. Advocacy pamphlets are displayed in the entrance to the facility. Caregivers interviewed were aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy.
<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	The service maintains key linkages with other community and external groups including churches and schools. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Discussion with staff, residents and relatives, determined that residents are supported and encouraged to remain involved in the community.
<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	There is a complaints policy to guide practice. The clinical nurse manager leads the investigation and management of complaints (verbal and written). There is a complaints and compliments register. Complaints are discussed at the monthly staff meeting. There have been eight complaints made in the period September 2019 to year- to -date. The complaints reviewed were investigated with the follow-up and outcome documented. One had gone to the Health & Disability Commission then the District Health Board (DHB) which investigated and closed with recommendations. Another went directly to the DHB and was closed with recommendations. Both included recommendations for specific education which has subsequently been delivered. Discussion with residents and relatives confirm they are aware of how to make a complaint. A complaints procedure is provided to residents within the information pack on admission.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. The clinical nurse manager or clinical coordinator discusses aspects of the Code with residents and their family on admission. Four residents (two hospital and two rest home) and four relatives (one rest home and three hospital) interviewed reported that the residents' rights are being upheld by the service and that they received sufficient information to be able to make informed choices on matters that affect them.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect. Staff received training on compassion and communication in May 2021.</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>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Māori consultation is available through local Māori services. Staff receive education on cultural awareness during their induction to the service and in ongoing training(November 2020). Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. At the time of the audit there were no residents in the service who identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the residents' plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregiver's role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. The General Practitioner interviewed was satisfied with the level of care that is being provided. Physiotherapy services are provided by</p>

appropriate standard.		referral or through the DHB. A dietitian is available on a referral basis. A podiatrist is on site every three months. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent. Residents interviewed state they are happy with the level of care provided and with the space and ability to personalise their rooms. The service has implemented policies and procedures that are reviewed. The policies and procedures meet legislative requirements. Caregivers interviewed state there are caregivers' guidelines in place to guide the delivery of care to residents.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Eleven incident forms reviewed identified family were notified following a resident incident. Interviews with staff confirm that family are kept informed. Four families interviewed confirmed they were notified of any changes in their family member's health status. Interpreter services are available as needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The service provides care for up to 80 residents across two service levels (rest home and hospital) in two 40-bed units (Karaka and Totara) which are further divided into two wings. All rooms are dual-purpose. On the day of audit there were 69 residents in the home with 40 rest home residents and 29 hospital residents (including one hospital level resident on an Enable contract) and one rest home level respite resident who was in the DHB hospital on the days of audit.</p> <p>The clinical nurse manager reports to the owner/director who lives locally and has a regular presence at the facility. Karaka Court Limited has a 2020 – 2021 business contingency plan that includes goals and objectives (including clinical) and a quality programme that includes monthly discussion about clinical indicators (e.g., incident trends, infection rates), at the two monthly staff meeting.</p> <p>The service is managed by a FTE clinical nurse manager (CNM) who has been at the facility for 3 years and has been in the aged care industry for 20 years. The CNM is supported by a clinical coordinator (RN) who has been at the home since 2019. There is a team of nine RNs who have experience within the aged residential care environment.</p> <p>The CNM and clinical coordinator have maintained at least eight hours annually of professional development activities related to managing a hospital through attending regular DHB provider meetings and training.</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 a temporary absence, the clinical coordinator will cover the clinical nurse manager's role (the managers role). Both the clinical nurse manager (clinical) and owner/director are on-call afterhours dependant on the issue (i.e., clinical vs non-clinical).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>Woodlands of Feilding has a quality and risk management system. There are policies and procedures (a nurse consultant was involved in the implementation of these) to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures align with current practice. The clinical coordinator collates incident and infection data. Data is recorded accurately and is reported at staff meetings (sighted).</p> <p>Quality matters are taken and discussed at the monthly quality/risk staff meetings. There are two monthly resident meetings. Meeting minutes demonstrate key components of the quality management system discussed including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings.</p> <p>Woodlands of Feilding has an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are seen to be resolved at the time. Corrective action plans are developed, implemented and signed off as completed when service shortfalls are identified. Internal audit results are communicated to staff at the full staff and RN meetings. A resident and relative satisfaction survey is completed annually. The 2020 satisfaction survey showed an overall satisfaction from residents and relatives with the service. The number of questions in the next survey is being reduced to try and illicit a greater number of responses. Only 16 relatives responded. Twenty- two residents responded.</p> <p>There is a H&S and risk management programme in place including policies to guide practice. A hazard register is in place. Health & Safety policy has been reviewed and reflects current H&S legislation. The CNM is the H&S Coordinator. Falls prevention strategies are in place that includes analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. H&S is included at the meetings for all staff. On audit there was a shortfall identified in</p>

		relation to health and safety.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data has been collected and analysed. A sample of eleven resident related incident reports for May 2021 were reviewed. All incident reports and corresponding resident files reviewed, evidenced that appropriate clinical care has been provided following an incident and all have been signed off. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise, and debriefing. Monthly and annual review of incidents is completed. Discussions with the owner/director and CNM confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>There are human resources policies to support recruitment practices. Nine staff files were reviewed (one clinical nurse manager, one clinical coordinator, one cook, two RNs, two caregivers, one diversional therapist and one cleaner) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed. A list of practising certificates is maintained. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files reviewed). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education and training calendar schedule for 2020 -2021 documented; however, there was no evidence that manual handling training had occurred in the last eighteen months including no training on how to use two recently purchased hoists. A competency programme is in place with different requirements according to work type (e.g., caregiver, RN and kitchen). Core competencies are completed, and a record of completion is maintained, with signed competency questionnaires sighted in files reviewed. There is a staff member with a current first aid certificate on every shift. There are currently eleven RNs (including the CNM and clinical coordinator) working at Woodlands of Feilding. Six of the 11 RNs are interRAI trained.</p> <p>In April 2021, nine registered nurses attended training by the hospice on end-of-life care. This hospice involvement continues with monthly hospice/RN meetings identifying residents that would benefit from hospice input directly or through staff training. Further End of Life education for all staff was given by the hospice at the end of May (20 staff attended). There has also been an education</p>

		session delivered by a DHB staff member on compassion and communication (13 staff attended).
<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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. All 80 rooms are dual-purpose. The roster allows for flexibility depending on the needs of the residents (i.e., hospital or rest home level). The roster (40 rest home residents and 29 hospital residents) includes the clinical nurse manager working five a week and the clinical coordinator three days a week or more. The clinical nurse manager is on call. There is at least one RN holding a first aid certificate on each shift. Staffing is as follows: two RNs on morning and afternoon duty and one at night, eight caregivers in the morning (various times), eight during the afternoon (various times) and four on night shift.</p> <p>There is a Careerforce assessor onsite. Fourteen caregivers have level I qualifications, two have level II, eight have level III and six have level VI.</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 resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</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 admission policies and processes in place. The admission pack included information about the service, the code of rights, consent processes, complaint process and the code of rights are included in the admission agreement included in the pack.</p> <p>Residents and family members interviewed confirmed they had the opportunity to discuss the admission agreement with the clinical nurse 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,</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 and utilise the pink envelope system. Relatives are notified if transfers occur.</p>

discharge, or transfer from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and senior HCAs complete annual medication competencies and medication education. Medication reconciliation occurs against the blister packs. There were no standing orders. Records of medication reconciliation are entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were no self-medicating residents on the day of the audit. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. All eyedrops and creams were dated on opening.</p> <p>Eighteen medication charts on the electronic medication system were reviewed. All charts had photo identification and allergy status documented. The effectiveness of 'as required' medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly.</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>	FA	<p>All meals are prepared and cooked on site at Woodlands of Feilding. The food service level is supported by cooks and kitchenhands. There is a four-weekly seasonal menu which has been reviewed by a nutritionist. Dietary needs are known with individual likes and dislikes accommodated. The menu offers a second meal option. Pureed meals, mince and moist and vegetarian meals are provided. Resident dislikes and food allergies are known and accommodated. Meals for residents are plated in the kitchen and transported to the dining rooms by bain-maries. Staff were observed assisting residents with their meals and drinks.</p> <p>A food control plan has been verified and expires in May 2022. There are daily chiller, fridge and freezer temperatures taken and recorded. End-cooked food temperatures are taken. Cleaning schedules are maintained. Dishwasher rinse and wash temperatures are monitored. All food services staff have completed food safety and hygiene and chemical safety.</p> <p>Residents have the opportunity to feedback on the food services through resident meetings and surveys. Residents and relatives commented positively on the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p>	FA	<p>The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available or the service cannot provide the assessed level of care. The referring agency, family and resident would be</p>

declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		notified.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files reviewed indicated that all appropriate personal needs information was gathered during admission in consultation with the resident and their relative where appropriate. An initial assessment and risk assessments were completed on admission. Risk assessment tools were completed including falls, pressure injury risk, pain assessment, dietary assessment and continence assessment. The outcomes of risk assessments were included in the initial assessment and long-term care plans. The first interRAI assessment had been completed for long-term residents within 21 days of admission and six-monthly as part of the six-monthly care plan evaluations, risk assessments are completed as part of the interRAI assessment.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	The long-term care plans are generated electronically, printed and placed in the resident files readily available for care staff. The long-term care plans reviewed overall described the support required to meet the resident's goal, however, did not always include the detail of all support required. 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. Short-term care plans are in use for changes in health status and either resolved or transferred to the long-term care plan as an ongoing problem.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Care plans reviewed were goal orientated and met the resident needs. Residents and relatives interviewed stated their needs are being met. If a resident's condition changes the RN initiates a GP consultation or specialist referral.</p> <p>There were 11 residents with wounds (six rest home and five hospital) including skin tears, lesions, and chronic ulcers. There was one hospital resident with a stage 2 pressure injury. Wound assessments had been completed for all wounds including measurements of the wound. Evaluations and change of dressings had occurred at the documented frequency. Chronic wounds had been linked to the long-term care plan. The RNs can access advice and support from the district nurses and wound nurse specialist at the DHB. There was sufficient pressure relieving devices in use and available.</p> <p>There is specialist continence advice as required.</p> <p>Monitoring records sighted included weights, vital signs, neurological observations, bowel records,</p>

		<p>food and fluids, blood sugar levels, pain, two hourly repositioning charts, fluid balance and challenging behaviour monitoring charts. Resident weights were noted to be monitored monthly or more frequently if necessary.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Two diversional therapists (DTs) run the activity programme. one has been in the role since November 2020, and the other since April 2021. The DTs work Monday to Friday from 9am to 4.30pm. Each resident has a monthly activity calendar. Activities are held in the lounges of both wings the craft room and in the foyer.</p> <p>Each DT implements the resident programme in their wing and includes (but not limited to); exercises, discussions, newspaper reading, quizzes, craft, ball games, walks, colouring and the blokes group. Activities meet the cognitive, physical and emotional abilities of the residents. Individual activities are provided in resident's rooms for residents who choose not to participate in the group activities. Celebrations and festive occasions are celebrated. There are regular community visitors including church groups, and entertainers. There are regular outings and scenic drives to cafés, picnics and places of interest. The service hires a wheelchair mobility van for hospital level residents for outings. The DTs have been trialling new activities, and gauge satisfaction on surveys around the topic and attendance. Residents also provide verbal feedback</p> <p>The DT completes a resident profile on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan which is evaluated six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>Residents have the opportunity to feedback on the programme through resident meetings and annual surveys. Residents and relatives interviewed were complimentary of the activities offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review (MDT) with the RN. There is a written evaluation against the resident goals that identifies if the goals have been met or unmet. In most cases long-term care plans are updated with any changes to meet the resident goals (link 1.3.5.2). Short-term care plans were evident for the care and treatment of short-term problems for resident's, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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. There was evidence of referrals to the need's assessment team for reassessment of a resident level of care from respite to rest home and for rest home to hospital level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly and safety data sheets and product information are readily available to staff. Gloves, aprons, visors and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility has a current building warrant of fitness that expires in January 2022. There is a maintenance man has overall responsibility for building compliance. There is a maintenance and repairs request book that is checked daily and signed as repairs are completed. The planned maintenance programme has been completed to date. Hot water temperatures in resident areas are maintained below 45 degrees. Essential contractors are available 24-hours. The facility has been fitted with RCD in all electrical outlets which cut out of there is a fault.</p> <p>The physical environment allows easy access/movement for the residents and promotes independence for residents with mobility aids. There is easy access to the outdoor areas for residents using mobility aids. There is outdoor seating and shade provided.</p> <p>The RNs and caregivers interviewed stated they have all the equipment required to deliver safe resident care.</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</p>	FA	<p>All rooms have ensuite facilities. There are communal toilets located close to communal lounges and dining areas with privacy locks. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares</p> <p>There are large mobility bathrooms for residents require shower beds.</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Woodlands of Feilding has a very large foyer area which has small seating areas within it, there is a chapel room, the hairdressing salon, a library and craft room off the foyer area. Each wing has a large open plan lounge and dining area, with access to central courtyards. All areas are easily accessible for residents using mobility aids.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Housekeeping staff are also responsible for attending to the laundry. Services are provided across seven days of the week. All personal clothes, towels and facecloths are laundered onsite. Bedding is outsourced and collected twice a week.</p> <p>The large commercial laundry has a dirty to clean flow, with two washing machines and commercial dryers. All chemicals are closed system. Data sheets are readily available. Regular laundry and cleaning audits are performed.</p> <p>The cleaning trolleys are locked in a chemical cupboard in the service area when not in use. There is one cleaning trolley in a locked sluice room for staff to access when domestic staff are not available. All domestic staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	Appropriate training, information and equipment for responding to emergencies is provided. There is an evacuation plan approved by the NZ Fire Service, which is dated 13 March 2017. A fire evacuation drill and education were last undertaken April 2021. There is staff across 24/7 with a current first aid certificate. There is an emergency management plan in place that covers health, civil defence and other emergencies. The civil defence kits are readily accessible. The facility is

<p>emergency and security situations.</p>		<p>well prepared for emergencies and has emergency lighting (will last 2 hours), gas BBQ for alternative cooking and access to a generator.</p> <p>Two 1,000 litre water tanks are installed next to the building. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery backup. At least three days stock of other products such as incontinence products and PPE are kept. There are supplies necessary to manage a pandemic. The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. There are documented security procedures in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is heated by gas underfloor heating. General living areas and all resident rooms are appropriately heated and ventilated. All rooms and communal areas have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control coordinator who is the clinical nurse manager. She is supported by the clinical coordinator and jointly they run the infection control programme which is linked into the quality management system and reviewed annually by the clinical nurse manager and the clinical coordinator. Infection control is an agenda item on quality</p> <p>Visitors are asked not to visit if they are unwell. Influenza and covid vaccines are offered to residents and staff.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator and her support have been in the role for some years and have attended external education 'bug control' seminars, DHB IC training in 2018 and were booked to undertake a further course March 2021 which is currently postponed. Education was undertaken onsite in January 2021 by the DHB infection control trainer. The infection control coordinator reports to management and staff meetings. The facility has access to an infection control nurse specialist through the DHB, public health, GPs, MOH and local laboratory. There is a folder of covid information available to staff. There is an outbreak management cupboard and ample stock of personal protective equipment that is checked regularly.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies (last reviewed May 2021) link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the annual training programme (last January 2021). Staff are required to complete infection control questionnaires and random monthly hand hygiene audits are undertaken. Any new communication regarding Covid-19 is relayed to staff via meetings, noticeboards and at handovers. Resident education occurs as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>Infection control data is discussed at the quality and staff meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule. The systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised.</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>There were six residents with restraints and 26 residents with an enabler in place. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enabler use is voluntary.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical nurse manager is the restraint coordinator. The restraint approval process and the conditions of restraint use are recorded on the restraint assessment form. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/whānau. The multi-disciplinary team is involved in the assessment process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. Assessments are undertaken by registered nurses in partnership with the family/whānau. The restraint assessment form is completed with input from the RN, and GP and the resident's family, and this was documented in the six resident's files for residents who use restraint. Three resident files were reviewed for restraint process and use, all had documented assessments, and consents. Risks were identified in the assessments, however, not all interventions and risks around restraint were documented in the care plan (link 1.3.5.2).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, is monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Three files were reviewed for residents with restraint. The review identified clear instructions for use of the bedrails, approval process, risks and monitoring requirements. Restraint monitoring records are completed by staff two hourly as instructed in the care plans. The restraint register is in place and is up to date.</p>
<p>Standard 2.2.4: Evaluation</p>	FA	<p>Three files were reviewed of residents requiring restraint. The use of restraint is evaluated six-</p>

<p>Services evaluate all episodes of restraint.</p>		<p>monthly as part of the GP review. All episodes of restraint are also monitored monthly through the RN meetings. There is no official restraint approvals group, however the clinical nurse manager, the RNs and the GP review and sign all restraints at least six-monthly with the family.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Internal audits around restraint are carried out regularly. Reviews were completed by the restraint coordinator, the RN and the GP. There have been no adverse events as a result of restraint use, however, the registered nurses, clinical nurse manager and the clinical coordinator could describe actions if this occurred. Restraint use is reviewed as part of the quality and RN meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>Actual and potential risks are identified however, the storage of oxygen cylinders was not safe.</p>	<p>Three of four oxygen cylinders observed in the facility were not secure so at risk of falling and exploding. There were no signs indicating where oxygen was stored so that staff/emergency personnel could be aware of the danger of inflammable goods.</p>	<p>Ensure all oxygen cylinders (full or empty) are secured and there is clear signage of where they are stored.</p> <p>30 days</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>There is an education and training calendar schedule for 2020 -2021 documented; however, there was no evidence that manual handling training had occurred in the last eighteen months including no training on how to use two recently purchased hoists.</p>	<p>There was no evidence that manual handling training had occurred in the last eighteen months including no training on how to use two recently purchased hoists. There was no evidence of competencies being undertaken for manual handling and transfer and/or hoist use.</p>	<p>Ensure that the manual handling training/hoist competencies are undertaken and a record of the same is maintained.</p> <p>90 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Low</p>	<p>Progress notes were documented at the end of each shift by the caregivers. The caregivers progress notes were in line with care plan interventions and provided detail of the care provided, and any concerns or changes to resident's condition. The registered nurses documented in the progress notes only if there had been follow up of a caregiver's concern, GP appointment or incident. Not all progress notes documented by the registered nurse were identifiable or documented within expected timeframes.</p>	<p>i). The registered nurse progress notes were not clearly identifiable, and there were periods of two or more weeks with no RN progress notes documented in two rest home and four hospital files.</p>	<p>Ensure all registered nurse progress notes are clearly identifiable and documented within expected timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Long term care plans were in place for all residents and were completed and reviewed in a timely manner, however interventions to assist caregivers to care for residents were not always documented in sufficient detail. The caregivers interviewed were</p>	<p>i). There was no instruction documented in the care plans for caregivers around oral cares for eight of nine files (five hospital and</p>	<p>i-viii). Ensure care plans are individualised and ensure interventions</p>

		<p>experienced and knowledgeable, and ensured the appropriate equipment and care was provided.</p>	<p>three rest home).</p> <p>ii). There were insufficient individualised details around management and de-escalation of challenging behaviour or anxiety for three rest home and two hospital residents.</p> <p>iii). There were no non pharmaceutical interventions documented in the care plan for one hospital and one rest home resident.</p> <p>iv). Advice and strategies from the GP for one hospital resident with challenging behaviour were not included in the care plan.</p> <p>v). Interventions were lacking around management of vertigo for one rest home resident.</p> <p>vi). There was no instruction around administration of a dietary supplement prescribed in the care plan for one rest home level resident.</p>	<p>adequately guide caregivers.</p> <p>90 days</p>
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			<p>vii). There were no instructions on how to place a CPAP machine on to a resident, required monitoring and signs and symptoms caregivers should be aware of documented in the care plan or included in the resident file.</p> <p>viii). There were no risks identified in the restraint care plan for six hospital residents using restraint.</p>	
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.