

# Elms Court Resthome Limited - Elms Court Rest Home

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## 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:** Elms Court Resthome Limited

**Premises audited:** Elms Court Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 16 July 2021 End date: 16 July 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 18

# Executive summary of the audit

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## 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

Elms Court rest home is certified to provide rest home level care for up to 18 residents. On the day of the audit there were 18 residents. Elms court is privately owned. The facility manager (co-owner) has been in the role since 2019. The clinical manager (registered nurse) has been in the role 2019 and has a background in age care nursing. They are supported by a team of experienced staff.

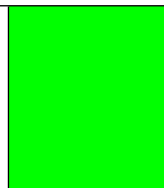
This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, including the review of residents' and staff files, observations and interviews with residents, relatives, staff the general practitioner and management. Residents, the GP and relatives interviewed were positive around the service for the support provided for residents.

There are embedded quality and risk management systems in place. An online education programme has been implemented and the service has a resident centred focus.

This audit identified no areas for improvement.

## 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.

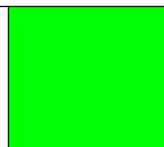
Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code), 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.

The business plan is tailored to reflect the goals of Elms Court rest home. There are policies and procedures to provide appropriate support and care to residents at rest home level care. This includes a documented quality and risk management programme that includes analysis of data. Meetings are held at regular intervals to discuss quality and risk management and to ensure these are further embedded into practice. There is a health and safety management programme that is implemented with evidence that issues are addressed in a timely manner.

An orientation programme is in place and there is ongoing training provided as per the training plan developed for 2021. Rosters and interviews indicated sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs. A roster provides sufficient and appropriate coverage for the effective delivery of care and support for residents. 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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There is an admission package available prior to or on entry to the service. The clinical manager/RN is responsible for each stage of service provision. The clinical manager/RN assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and were evaluated at least six-monthly. Medication policies reflect legislative requirements and guidelines.

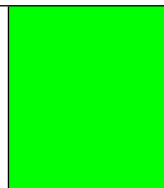
The clinical manager/RN and senior care partners (caregivers) responsible for administration of medicines complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The lifestyle coordinator provides and implements an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational preferences of the residents.

Residents' food preferences and dietary requirements are identified at admission and all meals and baking are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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.

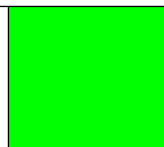


Standards applicable to this service fully attained.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. There are adequate communal toilet/shower rooms. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## 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.

Elms Court Rest Home has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training in restraint minimisation and challenging behaviour management.

## 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidence 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and staff interviewed (one general manager, one clinical manager/ registered nurse (RN), two care partners (caregivers) and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the online staff education and training programme. Training around the code of resident's rights has been completed between May and June 2021 using the online education platform.</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</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Permissions granted for general consents are included in the admission agreement as sighted in five of five rest home files, including one resident on the LTS-CHC contract and one younger person under Ministry of Health (MOH) funding.</p> <p>Consent forms are signed for any specific procedures such as the influenza and Covid-19 vaccine. Caregivers interviewed confirmed consent is obtained when delivering cares. The residents in shared rooms signed consent.</p> <p>Advance directives also identified the resident resuscitation status and signed by the resident (if appropriate)</p>

consent.		and the GP. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate. Discussion with three family members identified that the service actively involves them in decisions that affect their relative's lives. Five admission agreements were sighted.
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services. Information around the advocacy services is available beside the office.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents continue to participate in their chosen community group. The residents are supported to catch a bus nearby to attend community and church groups of their choosing and go on shopping trips.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The facility manager leads the investigation of any concerns/complaints in consultation with the clinical manager for clinical concerns/complaints. Concerns/complaints are discussed at the monthly quality/staff meeting as sighted in the meeting minutes. Complaints forms are visible throughout the facility. A complaints/ compliments register is maintained. Since the previous audit, there have been five compliments and one complaint received in 2020 and one complaint and two compliments received in 2021 year to date. Both complaints have been managed appropriately. Action has been taken within the required timeframes and resolved to the satisfaction of the complainants. Residents and families interviewed are aware of the complaints process. The 2021 satisfaction survey evidenced the residents were aware of the complaints process and how to make a complaint. This was an improvement since the 2020 survey, where few residents knew about the process. The complaint process is discussed regularly at resident meetings. Residents and relatives interviewed stated they felt comfortable discussing concerns with the management team.

<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 Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The general manager or clinical manager discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. Five residents and three family members interviewed reported that the residents' rights were being upheld by the service. The caregivers interviewed were knowledgeable around the role of the advocate and could easily describe where to find the pamphlets at the nurses.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. Caregivers confirmed they promote the residents' independence by encouraging them to be as active as possible and could easily describe instances where they respect privacy and treat residents with respect. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect using the online education system during orientation and ongoing education. The residents and relatives survey evidenced a high level of satisfaction around respecting privacy and dignity.</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. A Maori health plan is available for use as required. The caregivers interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care for any residents who identify with Māori. There were no residents who identified with Māori on the day of audit. Staff receive education on cultural awareness. The service has access to Maori liaison through the Christchurch district health board (CDHB).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive</p>	FA	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission in consultation with the resident and family. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual cultural and spiritual values and beliefs.</p>

<p>culturally safe services which recognise and respect their ethnic, cultural, spiritual 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>	<p>FA</p>	<p>Professional boundaries and code of conduct are discussed with each new employee during their induction to the service. Professional boundaries and staff expectations are also described in job descriptions. Interviews with the caregivers 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 appraisals.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Good practice around quality care including end of life care is evident. The clinical manager is available on duty or on-call 24 hours a day, seven days a week. Caregivers confirmed on interview they feel supported and their contribution into resident care is valued. Elms Court rest home has a stable experienced workforce with continuity, ensuring quality care for residents and trusting relationships with relatives. All staff hold relevant qualifications. Policies and procedures reflect best practice and staff are required to read and sign new/reviewed policies. Residents and family interviewed reported that they are very satisfied with the services received. There are several health professionals involved in the resident's care including the general practitioner. Annual resident and relatives' surveys are held evidencing a high satisfaction rate. The staff of Elms Court have supported four residents in stopping smoking and have a strong focus on promoting resident independence and accessing the community. Due to being a small facility, the staff get to know all of the residents and relative well, including likes, dislikes and preferences around routines, ensuring a very individualised approach to service provision. The manager and clinical manager are visible in the facility and promote an open-door policy. The manager/ owners are prompt in implementing changes and improvements to enhance quality of life for the residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Residents and relatives interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. Management operate an open-door policy. Thirteen incident/accident forms reviewed which identified family were notified following a resident incident. The facility manager and clinical manager confirm family are kept informed. Family members interviewed confirmed they are notified promptly of any incidents/accidents. Interpreter services are available if required.</p>

communication.		
<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>	FA	<p>Elms Court Rest Home is privately owned and operated and provides care for up to 18 residents requiring rest home level care. On the day of the audit, there were 18 residents in total, including three residents on the long-term support - chronic health contract (LTS-CHC), one on younger persons with a disability (YPD) and one individualised funding. All other residents were under the age-related residential care (ARCC) contract.</p> <p>The service is owned by a husband-and-wife team. The facility manager (wife) is non-clinical and has been in the role since 2019. She is experienced in human resources and business management. The clinical manager has been in the role since 2019 and has previous experience in aged care and senior nurse role.</p> <p>Elms Court has an annual business/ quality plan in place. The plan identifies progress achieving goals. The business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The manager/owner (husband) is responsible for the operational and financial aspect of the business and manages two other facilities.</p> <p>The facility manager and clinical manager have attended at least eight hours of professional development that relates to managing a rest home including a leadership and management study day, a courageous conversations study day, and they attend all of the inhouse education sessions.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the temporary absence of the facility manager, the clinical manager would perform management duties.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented,</p>	FA	<p>The business/quality and risk management plan and quality and risk policies describe Elm Courts quality improvement processes. Policies and procedures are maintained by an aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data. Where improvements are identified, corrective actions</p>

<p>and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>are developed, implemented and regularly evaluated. Information is shared with all staff as confirmed in meeting minutes and during interviews. Staff, residents and relatives interviewed confirmed any concerns they had were addressed by management and quality initiatives implemented.</p> <p>There are quarterly combined quality/infection control/health and safety meetings followed by the staff meeting. Meeting minutes evidence that quality data, trends and analysis, including areas for improvement is discussed including infections, accidents and incidents, health and safety, restraints/enablers, concerns/complaints, internal audit outcomes and quality goals. Quality data is discussed at handovers if there are emergent issues. There is an internal audit programme that covers environmental and clinical areas. The clinical manager completes a monthly summary of audits with corrective actions, which are signed off as completed.</p> <p>Annual resident/relative satisfaction surveys are completed annually. All residents and families were very satisfied with the care and services provided in 2021 evidencing a high level of satisfaction. There was an increase in meal satisfaction as regular feedback around meals has been implemented. Areas for improvement included the heating, in the colder days. The relative's satisfaction also evidenced a high level of satisfaction across all areas of the service.</p> <p>The facility manager is the health and safety officer. Staff receive health and safety training during orientation and is included in the education planner. Health and safety is discussed and documented in the quarterly quality/ infection control and health and safety meetings and the staff meetings. Emergent issues are discussed at handovers. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. The register is up-to-date and is reviewed six-monthly.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident. There is timely RN assessment including after hours for accident/incidents. Incident/accident data is linked to the quality and risk management programme. Thirteen accident/incident forms were reviewed. Each incident involved a resident clinical assessment and follow-up by a registered nurse. Neurologic observations were conducted for suspected head injuries. All incident reports are signed off by the facility manager. The facility manager and the clinical manager confirmed they are aware of their responsibility to notify relevant authorities in relation to essential notifications. There has been no requirement to complete a section 31 notification since the previous audit. There has been a respiratory outbreak which was reported to the public health team in a timely manner.</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>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Five staff files sampled (one registered nurse and four caregivers) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current and are completed annually. Current practising certificates were sighted for the clinical manager and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented. Attendance records evidence good attendance at education. Elms court have implemented an online education platform. There are sessions for staff to complete on a monthly basis, which includes all compulsory training sessions. All staff are first aid trained and completed core competencies including medications, wound care, manual handling, handwashing, and restraint.</p> <p>All staff are encouraged to complete qualifications through careerforce. Currently there are five caregivers with level 2 New Zealand Qualification Authority (NZQA) in Health and Wellbeing, one caregiver has level 3, and one caregiver has completed level 4.</p> <p>The clinical manager is competent in interRAI.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Elms Court has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The manager/owner is on site from 9 am until 3 pm Monday, Wednesday and Friday and from 9 am to 4 pm Tuesday and Thursday and is on call 24/7 for any operational issues. There is a clinical manager/RN on site from 8 am to 2.30 pm Monday and Friday, 6 am to 2.30 pm on Tuesdays, 8.30am to 4.30pm Wednesday, 2pm to 10pm on Thursdays, and is also on call 24/7 for any clinical concerns.</p> <p>There are two care partners (caregivers) on duty on the morning shift, 1x 6am to 2.30pm (medicine competent), and 1x 7am to 10 am (medicine checker) then goes to the kitchen from 10 am to 1.30 pm. The afternoon has two care partners rostered: 1x 2 pm to 10 pm (medicine competent) and 1x 4.15 pm to 6.15 pm kitchen shift (medicine checker). One care partner who is medicine competent works overnight from 10 pm to 6 am. All staff have first aid certificates.</p> <p>Roster shortages or sickness are covered by casual or off duty staff. The care partners and residents interviewed reported that there is sufficient staff cover.</p>
<p>Standard 1.2.9: Consumer</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial</p>

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>information recorded within 24 hours of entry into each resident's individual record. 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 the secured office. Archived records are secure in a separate locked area. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant wellness partner (caregiver) or RN, including 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>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and rest home care are provided for families and residents prior to admission or on entry to the service. Admission agreements reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The clinical manager/RN check medication against the medication chart and pack and signed in on the electronic medication system. All medications are stored safely. Medication fridges and room temperatures are checked daily and maintained within the acceptable temperature range.</p> <p>Eye drops are dated on opening. There was two residents self-medicating on the day of audit (inhaler). A self-medication competency had been completed and reviewed three-monthly by the RN and GP. Ten medication charts reviewed on the electronic medication system were reviewed and met legislative requirements. All medication charts had photo identification and allergy status documented. Indications for 'as required' medication were documented on the medication charts. There were no standing orders used.</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 and baking are prepared and cooked on-site by the cook/assistant manager Monday to Friday and a weekend cook. All staff have completed food safety training. The food control plan expires 18 February 2022. The four-weekly seasonal menu has been reviewed by a dietitian. Resident dislikes are known and accommodated. Meals are plated and served directly from the kitchen area to residents in the dining room. Fridge temperatures are taken daily and freezer temperatures weekly.</p> <p>End cooked food temperatures are taken on all foods daily and recorded. Perishable foods sighted in the fridge were dated. A maintenance and cleaning schedule is maintained. Dried goods in the pantry are dated and goods are rotated when orders are delivered. Resident meetings along with direct input from residents, provide feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for any dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The clinical manager/RN completes an initial assessment and care plan on admission including relevant risk assessment tools. Risk assessments are completed six-monthly or earlier due to health changes. InterRAI assessments were completed within 21 days of admission as sighted in three resident files admitted within the last six months. InterRAI assessments have also been completed for one resident on the LTS-CHC contract and one younger person under MOH funding. Resident needs and supports are identified through available information such as discharge summaries, assessments, medical notes and in consultation with significant others and included in the long-term care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	FA	<p>Resident care plans reviewed were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and sighted in resident files, for example, infections and wounds and have either resolved or if ongoing transferred</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>to the long term-care plan. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including gerontology nurse specialist, mental health services for the older person, podiatrist, pharmacist, dietitian and diabetes service as required.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the clinical manager/RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence the family/whānau contact sheet in each resident file that evidences family, were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Changes to resident's health are monitored and identified through ongoing daily assessments. Changes to health are reported to the clinical manager/RN who informs the GP or other allied health specialists. Adequate dressing supplies were sighted.</p> <p>Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for three residents (one skin tear, one lesion and two surgical wounds for one resident). Short-term care plans were in place for all wounds. There is access to a wound nurse specialist if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Monitoring forms and short-term care plans provide guidance for the safe delivery of care for short-term needs/supports. There were detailed interventions recorded in the files sampled for management of heart failure, challenging behaviour, weight loss interventions and hypo and hyperglycaemia.</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>The service employs a lifestyle coordinator with an occupational therapy background. She works 16 hours a week spread over four days a week. Working hours are flexible around resident activities such as outings. The programme included activities such as quizzes, word builders, exercises, walks, art and crafts, baking, music, happy hours, indoor bowls and news and views. Caregivers implement the weekend programme that includes movies and a regular entertainer. Residents are supported to attend community events including weekly visits to the Selwyn centre and attending concerts and minigolf in the community with other rest homes. A company car and taxis are used for outings to art galleries, museums and going to the movies. A weekly church service is held on-site. One-on-one time is spent with residents who choose not to participate in group activities.</p> <p>The lifestyle coordinator meets daily with the younger persons to ensure their individual recreational references are being met. They are offered to join in activities and are supported to maintain their interests/outings for</p>

		example toy museum, Beckenham church, coffee at the mall visits. A resident social profile is completed on admission. Individual activity plans were seen in the resident files. The lifestyle coordinator is involved in the six-monthly review with the clinical manager/RN. The service receives feedback and suggestions for the programme through resident meetings and surveys. Residents and relatives interviewed were satisfied with all on-site and community activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes for two of the five files reviewed. Three residents had not been at the service six months. Written evaluations reviewed for the two residents who had been at the service for over six months, identified if the resident goals had been met or unmet. The care plans had been updated with changes identified at the multidisciplinary review or earlier. Family are invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
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	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in a locked area within the facility. Bottles have manufacturer labels. Staff have completed chemical safety training. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.

result of exposure to waste, infectious or hazardous substances, generated 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 that expires 1 June 2022. Maintenance is overseen by the manager/owner and the maintenance person (previous owner) is on-site twice a week to address maintenance requests recorded in the maintenance book. The maintenance person also tends to the garden and grounds. There is a planned maintenance programme that includes two yearly testing and tagging of electrical equipment and annual calibrations of resident related equipment such as the chair scales. The maintenance programme was on schedule and any corrective actions dealt with in a timely manner.</p> <p>Essential contractors are available 24 hours. Hot water temperatures in resident areas are monitored monthly and have been maintained below 45 degrees Celsius. The facility corridors have sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and gardens. Seating and shade are provided. The caregivers and clinical manager/RN stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>There is a designated smoking area, and the service has taken reasonably practicable steps to minimise the escape of smoke into the facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is one bedroom with a full ensuite. There are adequate numbers of communal toilets and showers. There are privacy locks in place. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares.</p>
Standard 1.4.4: Personal	FA	There are 12 single resident rooms and three double rooms. Residents and relatives consent to sharing a

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>room. There are privacy curtains in place. There is adequate room to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, including the residents own furnishing and adornments.</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>	FA	<p>The rest home has a separate dining room with an open plan kitchen. There is a separate large lounge area with seating appropriately placed to allow for group and individual activities. All communal areas are accessible to residents. Care staff assist to transfer residents to communal areas for dining and activities as required. The garden and grounds are easily accessible.</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>	FA	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is done on-site by care staff. There has been a redesign of the laundry to easily identify the clean/dirty area and allow more space for the folding/sorting and ironing of personal clothing. There is appropriate personal protective wear readily available. The cleaner's trolley is stored in a locked area when not in use. Cleaning schedules are maintained. Internal audits monitor the effectiveness of cleaning and laundry processes. Residents and relatives are satisfied with laundry and cleaning services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring in July 2021. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (well water supply), blankets and alternate gas cooking (BBQ).</p> <p>There are civil defence and first aid kits available. Emergency equipment is available at the facility. There is a generator available on-site. Short-term backup power for emergency lighting is in place. A minimum of one</p>

		<p>person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The clinical manager/RN holds a current first aid certificate. There is a call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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>	FA	<p>Residents were provided with adequate natural light and safe ventilation. There are heat pumps in communal areas and wall heaters in resident rooms. The residents and family interviewed confirmed temperatures were comfortable.</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>	FA	<p>The clinical manager is the infection control coordinator with responsibility of overseeing infection control management for the facility. There is a job description outlining defined responsibilities of the role. The infection control coordinator provides reports to the management/quality team and the staff meeting. The infection control programme is reviewed annually. Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine and received Covid-19 vaccinations.</p> <p>There is a comprehensive Covid-19 site specific pandemic plan in place and outline the requirements and guidance under all the alert levels. PPE is available for daily use and plenty of stock is stored for pandemic use.</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</p>	FA	<p>The infection control coordinator has completed the on-line MOH infection control course in June 2021. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator can access support/advice from the infection prevention and control community team and the gerontology nurse specialist, GP, practice nurses and Southern Community laboratory.</p>

organisation.		
<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 and procedures appropriate for the size and complexity of the service. The policies have been developed by an aged care consultant and outlines a comprehensive range of policies including isolation procedures, management of MRSA, infection control standards and guidelines and includes responsibilities of the infection control team and training and education of staff.</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 policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred annually and includes hand hygiene competencies. Infection prevention and control is part of the staff orientation process. Resident education occurs as part of daily activities and cares. Residents are educated in handwashing and requirements under the Covid- 19 alert levels.</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>Infection surveillance is an integral part of the infection control programme and described in the infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. Short-term care plans are used for infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Meeting minutes with attached monthly infection analysis is available to staff. There has been one respiratory outbreak since the last audit (in August 2020) the necessary notification to Public Health was completed. Nine residents were affected, it was of short duration and well managed.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Elms Court Rest Home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.2. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint free environment. Staff receive training in restraint minimisation and challenging behaviour management.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.