

The Greenwoods House Limited - Epsom South Retirement Home

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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: The Greenwoods House Limited

Premises audited: Epsom South Retirement Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 16 February 2022 End date: 16 February 2022

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 20

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
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

Epsom South Retirement Home (referred to as Epsom South) is privately owned and operated. The rest home provides rest home level of care for up to 27 residents. On the day of the audit there were 20 residents.

This certification audit was conducted against the relevant Health and Disability Services Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff, management, and general practitioner.

There is a business & care manager appointed to oversee the facility with a registered nurse on site 20 to 25 hours a week. One of the directors is also a registered nurse with extensive experience in aged care who is able to support when required. Residents and family were very happy with the service provided.

There are two shortfalls identified around resolution of issues when identified, and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The staff at Epsom South Retirement Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. There is a documented Maori health plan to acknowledge the principles of the Treaty of Waitangi. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process.

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 low risk.
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Epsom South Retirement Home is one of four facilities owned by MA Healthcare Ltd. The business and care manager has been managing the facility since June 2021 and is supported by an assistant manager, and the clinical lead (registered nurse). There is a 2022 business plan in place. Regular audits take place as scheduled in the annual quality plan. There is a risk management programme, which includes incident and accident reporting and health and safety processes.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. Rosters and interviews indicate sufficient staff who are appropriately skilled, with flexibility of staffing around residents' need. There is ongoing training provided as per the annual developed training plan. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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An admission package is provided to family and residents prior to or on entry to the service. The registered nurse and the business and care manager along with staff rostered on are responsible for each stage of service provision. The registered nurses is responsible for assessment, care planning, and evaluation of care with the resident and/or family input. Resident files included medical notes by the general practitioner and visiting allied health professionals.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home residents.

Medication policies are documented. Medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts were reviewed at least three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is dietitian review of the menu. Residents commented very positively on the meals provided.

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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. External areas are safe with shade and seating available. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. Areas within the facility have been refurbished since the last audit.

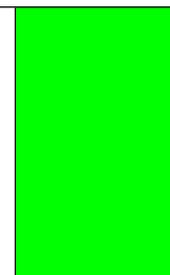
Restraint minimisation and safe practice

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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The service does not use restraint and there were no enablers used during the audit. Staff receive training around management of challenging behaviour at least annually.

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 prevention and control programme include policies, standards, and procedures to guide staff. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical lead (registered nurse) is the infection control coordinator and is responsible for coordinating/providing education and training for staff. The infection control coordinator collates data obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed. There have been no outbreaks since the last audit.

A pandemic plan has been actioned, and Covid-19 policies and procedures have been developed and implemented. The service continues to implement current Covid-19 regulations around contact tracing.

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	43	0	1	1	0	0
Criteria	0	91	0	1	1	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>Interviews with the business and care manager and four staff (one registered nurse (RN), one healthcare assistant (HCA), one cook, and one activity coordinator) confirmed their familiarity with the Code of Health and Disability Services Consumer Rights (the Code). Staff apply this knowledge to their daily practice. All staff receive training about the Code during their induction to the service and continue annually.</p> <p>Each resident's bedroom has a poster of the Code on the wall. Six residents and two relatives interviewed stated they receive services that meet the Code of Rights.</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>The service has policies and procedures relating to informed consent and advanced directives. All five resident files reviewed included signed informed consent forms and instructions around advance directives. Staff are aware of advance directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents identified that the service actively involves them in decision making.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services is included in the resident information pack and is provided to new residents and their family on arrival. Advocacy brochures and contact numbers are available in the lounge (the main entrance area). The complaint process is linked to advocacy services with this offered to any complainant if required. Staff receive annual education and training on the role of advocacy services. Staff have had training around advocacy in 2021.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups as covid 19 restrictions allow. Assistance is provided by the care staff to ensure the resident's participation as much as they can safely and desire to do so, as observed during the audit. The Maori resident attends the local Marae activities through Greenlane Maori Advocates regularly.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. Information about the complaints policy and procedure is provided on admission. The manager and the RN operate an 'open door' policy. Residents and relatives confirmed they are aware of the complaints process. The HCA interviewed was able to describe the process around reporting complaints.</p> <p>There is a complaint register held in a paper form. Three complaints were lodged from 2021 to 2022 year to date. There was documented evidence of each complaint being acknowledged, investigated, and resolved in a timely manner. Sighted monthly staff and quality combined meeting minutes confirmed complaints were discussed at the meetings. There have been no external complaints since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information of the code of right and advocacy are available at the entrance of main living area, which is explained to the residents and their families or power of attorney (EPOA) on entry to the service by the operator or Clinical Lead. Each resident's room is provided with a hard copy of the Code of right, complaint process chart and form. Residents and relatives stated they received adequate information on resident rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>Staff interviewed can describe correctly what 'privacy' means to them and the residents. Healthcare assistants interviewed reported that they are always knock-on doors prior to entering the rooms, as</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>observed during the audit. Resident's independence is encouraged at all times. Cultural and spiritual beliefs and information is incorporated in the residents' care plan, and advisors are available when required. There is a policy on abuse and neglect. Staff receive annual 'Abuse & Neglect' training, which has been scheduled in April 2022.</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>There is a Maori health plan in place. At the time of the audit there was one resident who identified as Māori living at the facility. Maori consultation is available through links with Greenlane Maori Advocates who can provide advice and support as required and enhance their culture understanding of treaty expectations and provision. The staff interviewed were able to explain how to meet the cultural needs of residents identifying as Maori.</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 staff interviewed were aware of the importance of meeting individual needs of residents. Individual culture and spiritual beliefs are incorporated into their care plan and reviewed regularly. Family/whanau are invited to attend this process. Staff receive annual culture competence training, and this year's training has been scheduled in April 2022.</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>There are policies and procedures to protect residents from abuse. The GP and staff interviewed stated that there was no evidence of abuse or neglect in the service. Code of conduct is part of the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. The HCA interviewed confirmed their understanding of professional boundaries. Job descriptions outline scope of practice.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Epsom South Retirement Home has established systems and processes. All policies and procedures, which have been developed in line with current best practice and reviewed regularly. The 2022 business plan outlines a number of priorities such as maintain competitive market pricing, and update brochures etc. Staff interviewed feel that they are well supported by the management with their professional development. Residents interviewed spoke positively about the care and support provided. Epsom South has an annual calendar for monthly training and audit activities. These</p>

		programmes demonstrate the commitment for continuous quality improvement and staff professional development. The recent staff satisfaction survey was completed in Feb 2022 with 100% participation rate. All were very satisfied with the service and care provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and their families receive explanation about the services and procedures on the entry. Interpreter services are made available to those residents who have difficulties with verbal or written English. There is one resident with very limited English. There were three staff who spoke the same language as the resident who stated that they were very happy with the service provided. Families interviewed stated they were kept well informed on their resident's health status. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Epsom South Retirement Home offers rest home level care for up to 27 residents. On the day of audit there were 20 rest home residents in total, including 12 under the Aged Related Care Contract (ARCC), three residents under the young persons with a disability (YPD) Contract, two residents under the Long-Term Support - Chronic Health Care (LTS-CHC) contract, one resident under a mental health contract. The service had verbal confirmation that two new residents had been assessed at rest home level of care under the ARCC however the service was waiting for confirmation of this. There is a 2022 business plan with goals, timeframes, and responsibilities. The quality programme annual calendar sets the whole year's quality activities. The business and care manager who has been in the role since June 2021 and has a background in pharmaceutical field. They are supported by an assistant manager who joined the organisation in September 2021. The clinical Lead (registered nurse) works five hours a day, five days a week. The chief executive officer (director/RN) is available for on call 24/7 if the clinical lead is not available. The facility manager has attended at least 16 hours of training in relation to managing an aged care facility.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and	FA	The assistant manager and business and care manager can relieve for each other if one is on leave. The chief executive officer relieves for the registered nurse when on leave.

<p>effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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 Low</p>	<p>Epsom South Retirement Home has an established quality and risk management system. There are policies and procedures in place to ensure the service is meeting accepted good practice and adhering to relevant standards. The 'quality management annual calendar' schedules monthly activities. A document control process is in place.</p> <p>There is a monthly combined quality/health and safety/ infection control/ staff meeting. Minutes sighted confirmed there is lack of documented evidence of resolution of issues in response to the corrective action plans documented as a result of the review of quality data, audit outcomes, operational issues and concerns/complaints between July 2021 and Jan 2022. It was noted that the gaps occurred during the times of lock down related to Covid 19.</p> <p>The monthly health and safety meeting has a regular agenda. The meeting minutes confirmed that the corrective actions were taken with evidence of resolution of issues. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. There is a health and safety check monthly. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a health and safety competency completed by staff as part of orientation. There is a hazard register, which is being reviewed monthly by the health and safety representative.</p> <p>Resident/family satisfaction surveys are completed six-monthly. The recent survey was conducted in February 2022. Overall satisfaction survey result (91.33%) which was consistent with the previous survey. There were no areas for improvement identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident and accident data is collected and analysed monthly by the business manager and a report is completed for the monthly quality/staff meeting. A total of 14 incident/accident files (eight unwitnessed falls, one witness fall, two away without leave, three challenging behaviours) were reviewed. Neurological observations were documented for unwitnessed falls or when a resident had hit their head by the clinical lead (if called in when on call or if on site). If the clinical lead was not on site, the HCAs completed a version of the neurological observations that included vital signs, observations of the resident, etc. Staff interviewed stated that they would always call emergency services directly if they were concerned or would call the clinical lead if they were concerned. The appropriate actions were taken in the incidents reviewed. Family members were notified accordingly. Staff/quality meetings reviewed confirmed that incidents were discussed with improvements to care made if required.</p>

		<p>The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, and corrective action to minimise and debriefing.</p> <p>There had been no serious complaints or notifications required to HealthCERT of external agencies since the last audit. There have not been any outbreaks.</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 including one business and care manager, three HCA, one clinical lead were reviewed, and all had relevant documentation relating to employment. Annual practicing certificates were maintained for qualified staff 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 were able to describe the orientation process and believed new staff were orientated well to the service. Care staff complete competencies as part of orientation relevant to their roles.</p> <p>There are one HCA who had completed Level 4 Careerforce training, two HCAs completed level 3 training, two completed level 2 training, and one completed level 1 training.</p> <p>There is an annual training plan that is outlined on the annual calendar. A core competency programme for HCAs and clinical lead includes pressure injury, manual handling, and medication management. Core competencies are completed, and a record of completion is maintained. The clinical lead attends Auckland DHB training programme quarterly. Staff interviewed were aware of the requirement to complete competency training and commented that the current education programme was informative and interesting. All staff have current first aid certificates.</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>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increases in staffing depending on the acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered, and a review of rosters confirmed that staff are replaced when on leave.</p> <p>Interviews with staff confirmed that they feel that staffing levels are sufficient to meet the needs of residents. The business and care manager and assistant manager both work 40 hours per week and the clinical lead is working between 3pm-8pm from Monday to Friday. The CEO is on call if the clinical lead is not available.</p> <p>All residents are independent. There were overlaps of HCAs between shifts for mealtime. Both facility manager and assistant manager assist resident during busy times.</p>

		<p>There is one HCA on morning shift (7am-5pm), one HCA on afternoon shift (3pm-11pm) and one on night shift (11pm-7am).</p> <p>There are designated staff for activities, food services and laundry/housekeeping.</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 service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident files are protected from unauthorised access. Resident files are integrated.</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>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the Age-Related Residential Care (ARRC) contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</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>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There are currently no residents self-administering. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses a paper based and medi- pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The clinical lead and medication competent HCAs administer all medications. Staff attend annual education and have an annual medication competency completed. There are currently no residents charted eye drops, but the clinical lead stated that eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the paper-based system. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the general practitioner. Photo</p>

		<p>identification and allergy status was recorded on each resident file. As required medications had indications for use charted.</p> <p>The ambient temperature of the medication room has been recorded and is maintained at less than 25 degrees Celsius. The medication fridge temperature is checked and recorded within expected ranges.</p> <p>The staff member administering medication was observed while giving lunchtime medications. There were elements of practice that required improvement.</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>There is a well-equipped, clean kitchen and all meals are cooked onsite. The service has two cooks who cover Monday to Sunday. Both cooks have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The cook interviewed was knowledgeable around the nutritional requirements of the residents. The four weekly menu cycle was last approved by a dietitian in February 2022.</p> <p>The temperature of the food is checked before serving. Meals are served straight from the kitchen on trays. Meals are covered with lids to keep them warm. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be hot and well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. The food control plan was verified on 19 February 2022. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. All residents interviewed were satisfied with the meals.</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>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The clinical lead completes an initial assessment and care plan on admission to the service which includes relevant risk assessment tools including falls risk, detailed pain, pressure injury, skin, continence, and nutritional assessments. Risk assessments are completed six-monthly or earlier due to acute health changes. InterRAI assessments and long-term care plans were completed within the required timeframes, and outcomes of assessments were reflected in the needs and supports documented in the care plans. Other available information such as discharge summaries and plans, allied health notes, and consultation with resident/relative or significant others are included in the long-term care plans. The outcomes of assessments form the basis of the long-term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are used for changes in health status e.g. urinary tract infections. Residents interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the mental health care team for older people and the eye clinic for one resident. The care staff interviewed advised that the care plans were easy to follow.</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 changes the clinical lead initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. Interventions are documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>There are currently no wounds or pressure injuries. Previous wound documentation showed that wound assessment, wound management, and wound evaluation was completed, and wound monitoring took place as documented.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, and wounds.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>There is one activities coordinator who has been in the role for one year. They have had four years previous experience as an activities coordinator in a previous rest home / hospital. They have a level seven diploma in strategic management and work twenty hours a week. The activities coordinator was interviewed and explained how there were group activities offered along with individual activities.</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>On the day of audit residents were observed to have an exercise group session, to be watching sport on TV, listening to music, and going for walks outside.</p> <p>There is a weekly programme in large print in the lounge area. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, mental stimulation, kiwi quiz, social activities, walks outside, music, arts and crafts, quizzes, and games. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. Some residents choose to go out to church every Sunday and the facility will take any others who wish to attend.</p> <p>Younger residents are very independent and access their own activities in the community.</p> <p>There is a monthly van outing with two vehicles to transport residents. Special events like birthdays, Easter, Mothers' Day, Anzac Day, and the Melbourne Cup are celebrated. Entertainers visit the facility. Residents were engaged in community activities however the Covid 19 pandemic has temporarily stopped residents engaging in these. One resident buses outside a supermarket and others shop in local areas when they like.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held monthly.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Except for the new admission all plans reviewed had been evaluated by the clinical lead six monthly or when changes to care occurred, which reflect the residents progress towards meeting goals. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that she is they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to an eye specialist, dental</p>

<p>(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>		<p>services, mental health services for older people and physiotherapy. Discussion with the clinical lead identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</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>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in a locked area. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. All staff have completed chemical safety training in 2021</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>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 28 September 2022. There is no maintenance person on site, but contractors are contacted as required. The clinical lead has a preventative and reactive maintenance book. The chief executive officer (director) and business and care manager complete maintenance and gardening duties as required. Contracted plumbers and electricians are available when required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked and calibrated annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range.</p> <p>The communal lounges, hallways and bedrooms have vinyl or tiled flooring. The corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>The HCA interviewed stated there is adequate equipment to safely deliver care for rest home level of care residents.</p> <p>The chief executive officer (director) has refurbished areas of the facility and upgraded furniture. The facility looked clean and well maintained on the day of audit. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</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>All rooms have hand basins. Ten rooms have shared ensuites (toilet only). There are also six communal toilets and showers. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if appropriate. There are signs on all shower/toilet doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</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>There are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining room is spacious. There is a small niche with a stepper for exercise which is for resident use.</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>All laundry is done on site. Laundry is completed by the HCA's. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and safety data sheets in place. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system.</p> <p>The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There is a sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept locked when not in use. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is a Zealand Fire Service approved evacuation scheme in place.</p> <p>The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There is a fire and emergency manual documented and available to staff. There is a civil defence emergency kit in the clinical lead's office. This is checked monthly. A generator would be hired if required. There is an emergency supply of 1080 litres of water available on site. There is annual civil defence training with this completed by all staff. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in proximity.</p> <p>There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. A first aid trained staff accompanies residents on outings. The facility is securely locked at night. Staff complete two hourly security rounds. There is security lighting. All staff (except the cook) have current first aid certificates.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. There is oil column heating in all areas. There are external windows in each room, and panel heaters with temperatures able to be adjusted in each room. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free. Staff and residents have been offered smoking cessation programmes.</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</p>	<p>FA</p>	<p>There is an infection control (IC) coordinator (clinical lead) who is responsible for infection control across the facility. The coordinator liaises with and reports to the business and care manager and chief executive officer (registered nurse/director). The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator.</p> <p>Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks and the</p>

the service.		response to the Covid 19 pandemic has been and continues to be in line with the Ministry of Health (MOH) guidelines and policies. The clinical lead has maintained effective communication with the MOH representatives during the pandemic with evidence of this documented.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IC coordinator is an experienced nurse. They have access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by an external infection control specialist. Policies, procedures, and guidelines written by the MOH for the Covid 19 pandemic have been downloaded, read, and put in a folder for staff to access.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and training for 2021 is also completed. Staff complete an infection control competency with this recorded in their staff file. Resident education occurs as part of providing daily cares and as applicable at resident meeting. Residents interviewed stated that they had been informed at all times of the expectations related to Covid 19 and the facility had been in lockdown during alert level 4.
Standard 3.5: Surveillance	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection

<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>		<p>control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports are completed for all infections. Infections are analysed for trends and quality improvements. Graphs and relevant information are communicated to staff and documented in management and staff/quality meetings.</p> <p>Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks and no residents have had Covid 19.</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>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. Staff have had training around restraint minimisation, safe practice, and management of challenging behaviours annually. There are no enablers or restraint used in the service.</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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action plans were documented when issues were raised e.g. from audits. There was lack of documented evidence of resolution of issues in meeting minutes when these were identified in quality data, audit outcomes, operational issues and concerns/complaints between July 2021 and Jan 2022.</p>	<p>Meeting minutes sighted did not document the outcomes of the corrective action plans</p>	<p>Ensure there is documented evidence of resolution of issues when corrective action plans are put in place.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>The staff member administering medication was observed when administering medication at lunchtime for residents. The staff tore off all the blisters from each pack for all residents needing medication at that time, left them on top of the trolley and then took the blister to a resident to administer. The staff member did check the blister against the prescription when they tore the off and ticked it to say that it matched. The staff member then took a blister, ensured that the resident had a drink to take with medication and gave them the blister. At one point, the staff member left the room to get water for the resident with the blisters on top of the trolley unsupervised. The staff member signed for the medication after it was administered.</p>	<p>Examples of poor practice were identified when observing a staff member giving medication to a number of residents at lunchtime. This included tearing off all blisters for all residents who had lunchtime medication prescribed prior to giving them to the individual resident and leaving medication on top of the trolley unattended.</p>	<p>Ensure staff follow correct medication procedures and guidelines.</p> <p>30 days</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.