

Opunake Districts Rest Home Trust - Opunake Cottage Rest Home

Introduction

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

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Opunake Districts Rest Home Trust

Premises audited: Opunake Cottage Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 20 July 2017 End date: 21 July 2017

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: 14

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

The Cottage Rest Home (The Cottage) is a community trust aged care service operated by the Opunake District Rest Home Trust. The Cottage offers rest home level care services for up to 22 residents. The positive feedback regarding the quality of the care and services and the community input and support are strengths of the service. There have been some changes to management since the last audit.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, families/whānau, one general practitioner, management and staff.

There are three areas identified as requiring improvement related to the development of the quality/risk plan, updating of policies and resident's self-administration of medicines. No other systemic issues were identified.

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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Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and family/whanau are informed of their rights during the admission process and ongoing residents' meetings. There are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service accessible throughout the service.

Residents and family/whanau receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs, including for those residents who identify as Maori. There are processes to access interpreting and translating services as required.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files sampled. There are advance care plans and advance directives that record the residents' wishes, with these respected by the staff.

The Cottage supports the right of residents, family/whānau and visitors to make a complaint. The service has a complaint register and the information is recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

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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The organisation's philosophy, mission and vision statements are identified in the strategic plan. The business plan contains quality objectives and risk management strategies.

There have been changes in the service's management. The service has a facility manager and a clinical manager, with the facility manager being responsible for the overall management of the service. The clinical manager oversees all clinical aspects of care.

The service is in the beginning stage of developing and implementing a new quality and risk management plan. The current quality management system includes an internal audit process, complaints management, incident/accident reporting, annual resident/family/whanau surveys and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and families/whānau, as appropriate. There is a process covering corrective action planning. Incident and accident management occurs to meet policy requirements; this includes reporting of adverse events to appropriate authorities.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

The privacy of residents' information is maintained with no private information on public display. The records are securely stored onsite.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The rest home provides resident focussed holistic services for the elderly and those needing care in the community. The rest home promotes independence, dignity and quality of life in partnership with staff, members of the health team, residents and

family/whanau. The clinical team is responsible for the development of care plans in consultation with the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. Residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medicines are administered by staff with current medication competencies. All medicines are reviewed by the general practitioner (GP) as required.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has processes in place to protect residents, visitors and staff from harm should exposure to waste or infectious substances occur.

There are documented emergency management response processes which are understood and implemented by staff. This includes six monthly fire evacuation drills.

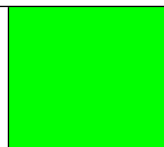
The building has a current building warrant of fitness and an approved evacuation scheme. There have been no changes to the facility footprint since the previous audit.

The environment meets resident needs and appropriate furnishings and equipment is provided. There is adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility is centrally heated throughout and there are opening doors and windows in all resident areas for ventilation. The outdoor areas provide furnishings and shade for residents' use.

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.

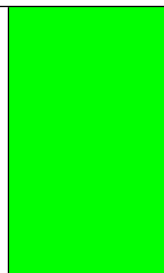


Standards applicable to this service fully attained.

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

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 residents, visitors and other service providers. The infection control coordinators are responsible for co-ordinating education and training of staff. Relevant infection

control education is provided to staff. Infection data is collated monthly, analysed and reported. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	0	90	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit interacted with residents in a way that respects residents' rights. The residents reported that they understand their rights, and all spoke highly of how they are treated by all staff. The family/whanau reported that residents are treated with respect and dignity.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated. Residents and family/whanau (where appropriate) are included in care decisions. There are guidelines for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. Advance directives and advance care plans are

		used to enable residents to choose and make decisions related to end of life care. The files sampled have signed advance directive forms and advance care plans that identify residents' wishes and meet legislative requirements.
<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>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service forms part of the in-service/online education programme. The staff reported knowledge of residents' rights and advocacy services. The support of an advocate is evidenced in the complaint management processes.</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>Policy includes procedures to be undertaken to assist residents to access community services and have visitors of their choice. Residents reported they are supported to be able to remain in contact with the community through outings and walks. Residents were observed to be going offsite, either independently or with family/whanau/friends. Family/whanau reported that their relatives are supported to attend off site cultural activities or places of worship if they themselves are not able to take them.</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>Policy and procedure reflect complaints management processes that comply with Right 10 of the Code. Complaint forms are available at the front desk and accessible to staff, visitors and residents. Staff confirmed that any complaints they receive are passed onto the owner/manager. Written complaints are placed in the complaints and compliments register which identifies all actions taken. Positive feedback regarding the quality of the staff and service are recorded for July 2017.</p> <p>There is one complaint (from multiple complainants regarding the one issue) recorded that was received through the DHB. This was partially substantiated and now closed, with the service implementing changes to address the concerns. There are no outstanding complaints at the time of audit. All complaints have been satisfactorily managed and closed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>On admission to the service residents and family/whanau are provided with information on the Code of Rights. Opportunities for discussion and clarification relating to the Code are provided to residents and their family/whanau. Brochures on the Nationwide Health and Disability Advocacy</p>

		<p>Service are on display at the service. The Code (in English and other languages) is on display.</p> <p>Education is provided on the Nationwide Health and Disability Advocacy Service as part of the in-service/online education programme. Residents are addressed in a respectful manner as was confirmed through observations and interview with residents and family/whanau.</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 privacy and dignity policy details how staff are required to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The service has several younger people and their independence and links with age appropriate community resources is encouraged. The residents interviewed and files sampled confirmed that individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect.</p> <p>Staff reported knowledge of residents' rights and understand the principles of dignity and respect and what to do if they suspected the resident was at risk of abuse or neglect.</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 cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. A commitment to the Treaty of Waitangi is included. The clinical manager has developed links with the local Iwi, marae and kaumatua.</p> <p>Family/whanau input and involvement in service delivery/decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. There were some residents who identified as Maori at the time of audit, with a file sampled reflecting culturally safe practice. A resident interviewed reported that their Maori beliefs are respected and supported by the staff. The resident reported they are satisfied with the care, support and environment at The Cottage.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values,</p>	FA	<p>The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific food preferences are identified on admission, with residents and family/whanau reporting the service 'excels' at meeting their cultural needs. The service is currently developing a policy on recognition of ethnic, cultural, spiritual values, and beliefs (refer to 1.2.3.3).</p> <p>Each section/need of the care plans incorporates the resident's individual cultural needs to provide</p>

and beliefs.		<p>guidance and ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Staff confirmed the need to respect the individual culture, values and beliefs of residents.</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>The employment position descriptions and the Code of Rights define residents' rights relating to discrimination. Staff stated they would report any inappropriate behaviour to the owner/manager (or clinical manager). The staff contracts and files confirmed that professional boundaries are included and the registered nurses (RNs) have attended the required Nursing Council of NZ Code of Conduct training. There was no evidence of any behaviour that required reporting and interviews with residents and families/whanau indicated no concerns. All residents and family/whanau interviewed reported high praise for how they are treated by all levels of staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies and procedures based on evidence based practice, which are currently being reviewed (refer to 1.2.3.3). The planned education programme sampled included sessions that ensure an environment of good practice. The service has access and support from visiting specialist nurses, palliative services and mental health teams. The general practitioner (GP) visits the service at least weekly, and at other times as required to respond to changes in a resident's condition.</p> <p>Residents' and family/whānau satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided. The GP reported the service provides 'excellent' quality of clinical care to residents at the different levels of care, with some residents being 'very complex'. The GP also commented that the clinical manager has excellent clinical knowledge and assessment skills and the clinical nurse shares this knowledge with other nurses.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family/whānau stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure even though the service is still developing a policy on open disclosure (refer to 1.2.3.3).</p> <p>Staff know how to access interpreter services, though reported this was rarely required due to all</p>

		residents being able to communicate effectively in English or Te Reo.
<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>The Cottage is owned and administered by a charitable community trust that provides rest home level of care for up to 22 residents. There were 14 rest home residents at the time of audit, which included one resident for palliative respite. There were no residents under the age of 65. The Cottage has funding contracts with the district health board (DHB) to provide aged related residential care (rest home), residential respite - rehabilitation support services, and long term support for chronic health conditions.. The staffing levels were increased at night to ensure the specific needs of the palliative resident can be managed. The facility is a member of an aged care association, and receives regular updates regarding aged care issues. The last resident satisfaction survey results records 97% overall satisfaction with several comments recorded regarding excellent care and friendly, caring staff.</p> <p>The 2017 strategic plan includes the philosophy and mission statement. The strategic plan includes strength, weakness opportunities a threats analysis of assets maintained and development, acknowledgement of Tikanga Maori, marketing and promotions, community partnerships, quality assurance and risk management, financial control and service delivery. From the analysis, there are corrective plans that record the objectives, task, measurable outcomes and expected achievements to address the identified shortfalls. The facility manager provides a monthly report to the trust board for ongoing monitoring of the service's objectives.</p> <p>The service has been going through a change of management process in 2017, with new people in the roles of facility management, clinical management and nursing The Cottage is making sound progress with reviewing, making improvements and implementing changes in the clinical policies, procedures and processes (refer to 1.2.3). The management roles, accountability and responsibilities for each role was clearly described in the job descriptions and contracts sampled.</p> <p>The facility manager has managed the service since January 2017, and has worked at the service for over eight years in administration, caregiving, activities and health and safety roles. The facility manager is also supported by a full time clinical manager who is a registered nurse (RN) with a current practicing certificate. The management team work together to ensure all residents' needs are met by the services provided. All members of the management team have attended over eight hours' education and professional development related to aged care management. The clinical manager also attends regular education to maintain their skills and knowledge.</p>
Standard 1.2.2: Service Management	FA	During a temporary absence of the facility manager, the clinical manager undertakes the role with assistance from members of the trust board. When the clinical manager is on leave, it is

<p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>anticipated that the casual RN will take on this role. During interview, the facility manager confirmed they are confident in the clinical management and RN to take on any management responsibilities during their temporary absence.</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>The service is currently developing a quality and risk management plan and reviewing their policies and procedures (refer to 1.2.3.7 and 1.2.3.3.). During this time the service is making improvements to the overarching quality and risk management plan including the implementation of internal audits and checklists to monitor the key components of service delivery. Internal audits are currently being conducted on management and clinical aspects of the service. Staff meeting minutes sighted identify that all quality and risk data is shared and they cover the key performance indicators. A summary of quality data is included in the monthly report to the board</p> <p>The results of the internal audits and other quality data such as incidents/accidents and infections are collected, reviewed and analysed. The corrective actions that are documented show outcome results following management review. Staff confirmed they are informed of all required corrective actions at staff meetings or at shift handover.</p> <p>Quality improvements are undertaken to meet the requirements of the standard and quality improvement records were sighted for medication management, wound assessment and falls management.</p> <p>Actual and potential risks are identified in the hazard register and strategic plan. The hazard risk assessment, risk assessment matrix and hazards register record the likelihood, consequence and rating score. Actions are implemented to eliminate or minimise the risk of occurrence. Staff confirmed that they understood and implemented documented hazard identification processes. Newly found hazards are discussed, monitored and managed by the manager/maintenance person with staff input.</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</p>	<p>FA</p>	<p>Adverse event reporting, as identified in policy, is implemented by the service. Policy outlines all reporting requirements including Section 31 of the Health and Disability Services (Safety) Act 2001. The owner/manager confirmed their awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations. One Section 31 notification to the Ministry of Health was sighted.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is documented. Information is shared at staff meetings, as</p>

manner.		<p>confirmed in minutes sighted. Documentation in residents' files and the 2017 incident and accident forms reviewed identified that all issues reported had corrective actions put in place when required. The incident and accident forms are viewed and signed off by the owner/manager.</p> <p>The principles of open disclosure are evident with clearly documented family/whānau notification of any adverse event or concerns staff may have about a relative's health status. This was confirmed during family/whānau interviews.</p> <p>Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated and examples were given. Incident and accident numbers are trended and if there is an increase identified appropriate actions are taken.</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>	FA	<p>All positions have a documented position description that describes staff responsibilities and accountabilities. Staff complete an orientation programme with specific competencies for their roles. Staff confirmed during interview that the orientation/induction process is overseen by a senior member of staff and that they felt confident to undertake their roles upon completion.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and annual staff appraisals. RN has current interRAI training with the other RN on the waiting list for training.</p> <p>The education calendar sighted for 2016 and 2017 identifies that staff are offered and undertake training and educational topics relate to aged care and health care services. The service is making changes to the annual education plan, though the existing plan that they are currently working from covers the contractual requirements. Education sessions are presented at the facility and staff are informed of upcoming off-site education sessions. Attendance for all education is documented in staff files.</p> <p>Caregivers are encouraged to undertake a recognised aged care qualification. RNs have undertaken the required hours of education to meet Nursing Council requirements. Members of the management team also attend workshops and seminars specific to management related topics.</p> <p>Resident and families/whānau members identified that staff act professionally.</p>
Standard 1.2.8: Service Provider Availability	FA	<p>Policy that identifies staffing levels and skill mix is maintained to meet residents' needs and to comply with contractual requirements. Documentation identified that adequate numbers of suitably</p>

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>qualified and experienced management, clinical and care staff are rostered on duty. The service also has kitchen, activity, cleaning, administration and maintenance staff. All staff assist with laundry as part of their everyday duties.</p> <p>Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents' needs. There is at least one RN on duty for the morning shift Monday to Friday and on call at other times There is least one staff member on each shift who holds a first aid qualification. Additional staff are rostered to reflect the occupancy and workload, such as with a recent admission requiring palliative care.</p> <p>Resident and family/whānau members stated all their needs have been met in a timely manner.</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>Personal information was entered in all residents' records sampled. entries are being documented at appropriate intervals, are legible with signatures and staff designations included. All individual records were integrated with divisions labelled accordingly.</p> <p>The records are stored at the nurses' stations which have locked access. There were some records (such as short term care plans/wound treatment plans) kept in a separate folder, these were integrated into the residents' record when the issue is addressed (the resident's main file referring the reader to any other associated documents). Residents' other personal/financial documents are stored in the owner/manager's office. A system is in place for accessing archived records when required.</p> <p>Resident information is not displayed on public view without consent being obtained.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Opunake Cottage Rest Home's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whānau of choice where appropriate, local communities and referral agencies.</p> <p>Files sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives interviewed confirmed that they received sufficient information regarding the services to be provided.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A referral form is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</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 Low	<p>The medicines management system is implemented to ensure that residents receive medicines in a secure and timely manner and medicine charts sampled complied with legislation, protocols and guidelines. Medicines were stored safely and securely in the treatment rooms and locked cupboards. Medicine reconciliation is conducted by the clinical manager and RN when the resident is transferred back to the service. The organisation uses pre-packed medicine packets which are checked on delivery. All medicines are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos are available to assist with identification.</p> <p>An annual medicine competency is completed for all staff administering medicines and training records were sighted. The clinical manager was observed administering medicines correctly. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medicines are stored appropriately. There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner.</p> <p>A self-administration policy and procedure is in place. An improvement is required regarding the competency assessment process for residents who are self-administering their medication.</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>Meal services are prepared on site and served in the dining area. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents' nutritional requirements are developed on admission which identifies dietary requirements, likes and dislikes. The resident's weight is monitored monthly and supplements are provided to residents with identified weight loss issues. The service provides meals on wheels to the community for a fee from Monday to Friday. The residents and family/whanau interviewed indicated satisfaction with the food service.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</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 clinical manager and RN interviewed reported that all consumers who were declined entry are recorded on the pre-enquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</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 initial assessments are completed within the required time frame on admission while resident centred care plans and interRAI are completed within three weeks per policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and family/whanau expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate resident centred care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</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>	FA	<p>The documented interventions in short term care plans and resident centred care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	FA	<p>The planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that</p>

delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		<p>they modify activities based on the resident's response and interests and per the capability and cognitive abilities of the residents.</p> <p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends. Community organisations provide activities at the service on regular basis. There are planned activities and community connections that are suitable for the residents. The residents and family/whanau interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident centred care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There is a documented process for the management of all referrals. The service utilises the facility referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the clinical team or GP.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policy is implemented to ensure safe and appropriate storage and disposal of waste substances. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff reported their understanding of safe disposal processes.</p> <p>Chemicals are stored securely and correctly labelled. Safety data sheets were sighted for the chemicals in use. There is a chemical products reference chart on the wall in the laundry area where the chemicals are stored.</p> <p>Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposable gloves and aprons as required.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness displayed.</p> <p>Maintenance occurs both as planned annual maintenance and day to day reactive maintenance. This includes the monitoring of hot water temperatures in resident areas. Specialised areas, such as plumbing and electrical work, is undertaken by external contractors and minor repairs are undertaken the maintenance worker.</p> <p>Electrical safety testing last occurred in July 2017. Clinical equipment is tested and calibrated by an approved provider at least annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip and walking areas are kept clear of obstructions. Staff verbalised their awareness of maintaining a safe environment.</p> <p>Outdoor areas are easily accessed by all residents and there is appropriate seating and shaded areas. Resident and family/whānau use of the outdoor areas was observed on the days of audit. Interviews with residents and families/whānau members confirmed the environment is suitable to meet 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>There are adequate toilet and shower facilities, with each of the wings having access to showers and toilets. Three bedrooms have a full ensuite. The residents reported satisfaction with the facilities provided.</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</p>	FA	<p>Most bedrooms are single occupancy and are of a size which allows enough space for residents to mobilise safely with or without assistance. There is one room that has the capacity to be a shared room suitable for a couple. The room currently has a single occupant. All rooms sighted are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. Resident and families/whānau members interviewed confirmed they are satisfied with their personal space.</p>

setting.		
<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>Residents are provided with adequate areas to meet their relaxation, activity and dining needs. The large lounge area is used by most residents. There is a separate dining area. Activities occur in the lounge as observed on the days of audit. Residents and families/whānau voiced their satisfaction with the environment.</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>The service has documented policies and procedures in place for cleaning and laundry tasks. The laundry and sluice areas have a dirty to clean flow. The laundering is undertaken on site and the staff confirmed they have adequate equipment to undertake this task. Laundry chemicals for the washing machines are on an automatic feed to ensure the correct amount of detergent is used for each wash.</p> <p>The chemicals for cleaning are kept in their original bottles which are clearly labelled. The cleaners' trolley is stored in secure areas when not in use.</p> <p>The residents and families/whānau confirmed they were very happy with the cleaning and laundry services provided.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Documented emergency management procedures are implemented by staff in the event of an emergency. The emergency plan is reviewed annually as part of the quality process. Emergency fire equipment is checked annually by an approved provider. The ACC workplace safety management system conducted in 2016 evidenced emergency preparedness at the tertiary level. The service is also part of the wider Opunake Community Emergency Plan.</p> <p>There is an approved evacuation scheme. Six monthly fire evacuations being undertaken, fire drills conducted and reported to the local fire service. There have been no changes to the facility footprint since this time.</p> <p>Emergency supplies and equipment include food and water, first aid kits and civil defence supplies. The contents are rotated regularly so that they do not expire. Six monthly checks were sighted. Alternative energy and utility sources (including generator) are available in the event of the main supplies failing and include emergency lighting and a gas BBQ for cooking.</p> <p>The security arrangements involve staff ensuring the doors and windows are locked at dusk. Staff and residents stated they feel safe. There is CCTV monitoring of the common areas and</p>

		<p>entrances, which can be seen on the screen in the nurses' office.</p> <p>Call bells are in all resident areas and all residents have personal alarms (watch button) to alert staff. Residents and families/whānau interviewed confirmed call bells were answered in an acceptable timeframe.</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>All resident areas have at least one opening window which provides natural light and ventilation. The facility has electric heating, central heating or ceiling heating/air-conditioning vents throughout the facility, including in resident bedrooms. Residents confirmed that the facility is maintained at a comfortable temperature throughout the year.</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>Opunake Cottage Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The infection control programme is linked to the quality improvement and risk management programme. The clinical manager and RN are the infection control coordinators (ICCs) and have access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC, including role and responsibilities, is in place.</p> <p>The infection control programme is reviewed annually and is incorporated into the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>

programme and meet the needs of the 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>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to comply with infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and could locate policies and procedures.</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>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections. Outcomes are fed back to the staff at the next staff meeting. The infection surveillance records included the review and analysis of the data. There is evidence that the service implements actions to reduce the recurrence and spread of infections.</p> <p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection.</p>

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Opunake Cottage Rest Home promotes a restraint free environment. The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained or using enablers on the day of the audit. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler.

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 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>The service is in the process of reviewing their policies and procedures and setting time frames for their ongoing review and ensuring they are linked to current good practice and legislative requirements. This policy review is also including a review of the education programme and processes for ensuring staff annual performance development appraisal are consistently completed. The management team and RN have developed a plan to schedule the policy reviews, update clinical processes and assessment/care planning forms, including service agreements. A schedule has been developed to ensure there are sufficient policies to meet the requirements of the standards and the needs of the residents (such as open disclosure, cultural/spirituality, use of interRAI and aspects of clinical service delivery). Staff have access to resource materials that reflect current pressure injury management.</p>	<p>Several policies were not current or reflective of, or evidenced to, current good practice.</p>	<p>Provide evidence that all policies and procedures are developed, implemented, aligned with current good practice, meet the requirements of legislation and are reviewed as</p>

				required. 180 days
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	Although quality and risk management activities are being conducted, the overarching quality and risk management plan is still currently being developed.	The quality and risk management plan is currently under development.	<p>Provide evidence that the quality and risk management plan has been completed and is being implemented.</p> <p>180 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>There were three residents who were self-administering their medicines (inhalers) at the time of the audit and their medicines were stored in a secure safe place, however a current competency assessment for these residents had not been completed. These residents were scheduled for review and a competency assessment by the GP during the audit. As the competency assessments have been scheduled and the residents interviewed demonstrated an understanding of the medicines they self-administer, the risk rating was assessed as low.</p> <p>Ten medicine charts were reviewed and identified that all medicines have been reviewed every three months and as required by the GP. Allergies are clearly indicated and photos are available to assist with identification. Medicines are stored in a safe and secure place. A self-administration policy and procedure is in place.</p>	The required competency assessments for residents who were self-administering their medications had not been completed.	<p>Complete the required assessments for the residents who are self-administering their own medications.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.