

Kerikeri Retirement Village Limited - Kerikeri Retirement Village

Introduction

This report records the results of a Provisional 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 and Disability Auditing New Zealand 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: Kerikeri Retirement Village Limited

Premises audited: Kerikeri Retirement Village

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 12 June 2018 End date: 12 June 2018

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: 66



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.

General overview of the audit

Kerikeri Retirement Village including the care facility is owned and operated by a community trust and governed by a board of trustees. A chief executive (non-clinical) is employed and responsible for the operations of the service. She is supported by a clinical manager, assistant clinical manager and quality risk coordinator. The service provides rest home, hospital and dementia level of care for up to 68 residents. On the day of the audit there were 66 residents.

The residents and relatives spoke positively about the care provided at Kerikeri Retirement Village.

There are no areas for improvement identified at their certification audit. The service has been awarded a continuous improvement rating around staff awareness of health and safety.

This provisional audit was undertaken to establish the level of preparedness of the prospective company to provide a health and disability service and to assess the level of conformity of the current provider prior to the company structure change. A certification audit was completed with the service on the 12-13 April 2018 and the consequent audit report was utilised as part of this provisional

audit. The certification audit was conducted against the Health and Disability Service Standards and the organisations contract with the district health board (DHB). The audit process included the review of policies and procedures; sampling of resident and staff files; observations; interviews with residents, residents' family members, management, staff, and a general practitioner.

The prospective provider is the same as the existing one, the change is to the company structure. Currently governance of the village is by the Kerikeri Village Trust trading as Kerikeri Retirement Village. The new structure will be Kerikeri Retirement Village Limited. Which will be a registered charitable company. The current six board members of Kerikeri Village Trust will become the six directors of Kerikeri Retirement Village Limited. There are no planned changes to management, policies, procedures, staffing or implemented processes.

Consumer rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as: privacy; dignity; abuse and neglect; culture; values and beliefs; complaints; advocacy; and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family state they are kept well informed on their relative's health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented and complaints and concerns are managed appropriately.

Organisational management

The prospective company structure will continue at an operational level with support from the management team. There are no planned changes to the current management team at Kerikeri.

Kerikeri Retirement Village has an implemented a quality and risk management system. Key components of the quality management system include: management of complaints; implementation of an internal audit schedule; annual satisfaction surveys; incidents and accidents; review of infections; review of risk; and monitoring of health and safety including hazards. The

health and safety, infection control and quality risk committee meeting includes discussion around quality data. Staff receive health and safety induction on employment and continuing education as part of the education plan. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. Staff attend full study days that includes mandatory training requirements and in-service.

Continuum of service delivery

There is a comprehensive admission package available prior to, or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three-monthly by the general practitioner.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. Residents and families report satisfaction with the activities programme.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

Safe and appropriate environment

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. A selection of residents' rooms has ensembles and there are sufficient communal showers/toilets for the others. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are constructed for ease of resident access and ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

Restraint minimisation and safe practice

There are policies and procedures on safe restraint use and enablers. A registered nurse/quality and risk coordinator is the restraint coordinator. There are two residents voluntarily using enablers and seven residents with restraints. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator/assistant clinical manager is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. Benchmarking occurs with other Northland aged care facilities.

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	50	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Seven residents (five rest home and two hospital level of care) and four relatives (two hospital level and two dementia level of care) interviewed confirm that information has been provided around the Code of Rights. Residents state that their rights are respected when receiving services and care. There is a resident rights policy in place. Discussion with five caregivers and four registered nurses (RN) identifies that they are aware of the Code of Rights and can describe the key principles of resident's rights when delivering care.</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 in place a policy for informed consent and advanced directives. Completed advanced directive forms are evident on all resident files reviewed (four hospital- including one young person with a disability, three rest home and two dementia -including one respite). General consent forms are evident on files reviewed. Discussions with staff confirms that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' charts.</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>	<p>FA</p>	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance.</p> <p>Interviews with the residents and relatives confirms their understanding of the availability of advocacy services. The chaplain is readily available to residents and families. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirm that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. There are many community visitors to the home including volunteers and village residents.</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>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints is maintained on the online complaint register. The chief executive and clinical manager manage complaints.</p> <p>There have been two internal complaints from March 2016 to March 2017. The complaints/concerns have been managed in line with Right 10 of the Code. A review of complaints documentation evidence resolution of the complaints to the satisfaction of the complainants. One complaint was received by the DHB and HealthCERT which was resolved and closed out. Residents and family members advise that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments are evident in facility meeting minutes.</p> <p>Complaints forms are available at the main entrance and in the</p>

		Paterson and Robinson corridors.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service has information available on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The Code of Rights (English and Māori) is also displayed in the resident areas. There is a welcome information folder that includes information about the Code of Rights. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission with the clinical manager. Residents and relatives state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</p> <p>With the prospective change in company structure, the board members will change roles to directors. Management does not change. The directors and managers continue to understand the Consumer Rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff are able to describe how they maintain resident privacy, including knocking on the resident's doors before entering, as observed on the day of audit. Staff attend privacy and dignity and abuse and neglect in-service as part of their education plan. Care staff interviewed state they promote independence with daily activities where appropriate. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relatives.</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 Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to Māori providers and interpreter services. The Māori health plan identifies the importance of whānau. Cultural assessment plan and evaluations of care for Māori are completed for those who</p>

		identify with Māori. A senior caregiver is the cultural advisor for the service. There were five residents who identify as Māori on the day of audit.
<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	The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six-monthly to ensure the resident's individual culture, values and beliefs are being met. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular church services in the on-site chapel. The service has an ordained lay Minister/spiritual advisor who has 25 years' experience in aged care as a diversional therapist.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The staff employment process meets best practice with regard to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Caregivers are able to describe how they build a supportive relationship with each resident. Residents interviewed state that they are treated fairly and with respect.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The management are committed to providing a service of a high standards, based on the provider vision, mission and values. This was observed during the day with the staff demonstrating a caring and respectful attitude to the residents. All residents and families speak positively about the care provided. The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Care staff and registered nurses (RNs) have access to internal and external education opportunities. Staff have a sound understanding of principles of aged care and state they are supported by management. Regular facility and clinical meetings and shift handovers enhance communication between the teams and

		provide consistency of care. A clinical & quality sub-committee which meets monthly has been initiated, comprising a pharmacist, a palliative care RN, the clinical manager and Q&R coordinator with a Doctor of Nursing (Gerontology) who joins by teleconference. The service employs a physiotherapist for 20 hours per week over 3 days who completes resident mobility assessments and provides safe manual handling training for staff.
<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>Management promote an open-door policy. Relatives/residents are aware of the open-door policy and confirm on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings and annual surveys. Results and areas for improvement are discussed at resident meetings (sighted in minutes). The resident meetings are bi-monthly and chaired by the chaplain. Residents and relatives receive quarterly newsletters.</p> <p>Accident/incident forms reviewed document that relatives have been notified of the incident. Relatives interviewed state they are notified promptly of any changes to resident's health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. An interpreter service is available if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Kerikeri Care Facility and Village has a charitable trust status and is governed by trustees, board members and four sub-committees. The board members have a range of expertise to support the chief executive and management team including: business management; law; clinical consultant; hospice; aged care; general practice; and pharmacy.</p> <p>The service can provide care for up to 68 residents. There are twenty-three rest home beds (this includes two double rooms that are currently single occupancy), twenty-six hospital beds, four dual-purpose beds and fifteen beds in a secure dementia unit. On the day of audit there were 22 rest home residents, 29 hospital residents (including 1 respite care resident and 1 resident under 65 years of age). There were 15</p>

	<p>residents at dementia level of care (including 2 respite care residents) in the secure dementia unit. There were no residents under medical services.</p> <p>The chief executive (CE) has been in the non-clinical role since July 2016 and has held senior management roles in the community sector. She is supported by an operations support manager with experience in human resources and administration. The clinical manager has seven years' experience in the role and is supported by an assistant clinical manager, quality risk coordinator and education coordinator. All are registered nurses with current practising certificates. The new organisational structure was implemented with the appointment of the CE last year. This has streamlined the business and clinical effectiveness and reporting channels.</p> <p>There is a 2016 – 2020 strategic business plan that is reviewed by board members at the annual general meeting. The operational quality goals for 2016 have been reviewed with a 2017 quality plan in place that includes the service vision, mission and values.</p> <p>The CE has attended a two-day aged care conference and is on the Northland DHB falls working group. The clinical manager maintains an annual practising certificate and has exceeded eight hours annually of professional development including leadership course, health and safety, aged care conference and conflict resolution.</p> <p>The prospective provider is the same as the existing one, the change is to the company structure. Currently governance of the village is by the Kerikeri Village Trust trading as Kerikeri Retirement Village. The new structure will be Kerikeri Retirement Village Limited, which will also be a registered charitable company. Kerikeri Retirement Village Limited will be governed by six voluntary directors (the original six board members) and three sub-committees. They have a range of expertise to support the chief executive and management team including accountancy, business management, hospice, IT, aged care, pharmacy and real estate. There are no planned changes to management, policies, procedures, staffing or implemented processes therefore a transition plan has not been required. The change of governance structure is intended to occur 1 July 2018.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the temporary absence of the CE, the clinical manager provides management oversight of the facility and the assistant clinical manager provides cover for the clinical manager. A current practising certificate for the clinical manager and assistant clinical manager were sighted.</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>FA</p>	<p>The service has a quality risk management plan in place that is reviewed annually. The service has a range of policies and procedures in place to support service delivery that have been reviewed regularly by the service. Staff are informed of any new/reviewed policies through handovers and meetings.</p> <p>There are regular management, service and clinical meetings and bi-monthly quality risk meetings. Meeting minutes' evidence discussion around a wide range of quality data. Trends are identified and analysed for areas of improvement. Caregivers confirm that they are kept informed on quality data including corrective actions and quality initiatives. Noticeboards have meetings minutes, graphs and relevant data posted. The service is benchmarked against four other facilities under the far Northland region. Statistics are collated and distributed three-monthly. The service is currently involved in the falls and pressure injury projects with the DHB.</p> <p>Internal audits are completed as scheduled including environmental and clinical audits. Corrective action plans are raised, completed and signed off for any corrective actions required. The quality and risk coordinator provides a monthly quality report to the clinical manager and board.</p> <p>The quality risk coordinator is the health and safety coordinator and they have completed the health and safety course and transition course. Staff are given the opportunity to provide input into the bi-monthly Health and Safety Committee meetings. Training has been provided for managers and committee members through an external consultant. Health and safety information is displayed on the staff noticeboard.</p> <p>Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case by case basis to</p>

		<p>minimise future falls. A falls analysis tool (face clock) is used to trend time and location of falls.</p> <p>On interview, the CEO states that policies and procedures and the current quality and risk management system will remain in place.</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>	FA	<p>As part of risk management and the health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to the management, Health and Safety Committee, clinical and facility meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.</p> <p>Sixteen incident forms (three rest home, seven hospital and six dementia care) were reviewed from February 2017. All incident forms are on the online system. All incident forms reviewed identify a timely RN assessment of the resident, corrective actions or recommendations and all had been completed and signed off by the clinical manager. The next of kin have been notified for all incidents/accidents. The caregivers interviewed could discuss the incident reporting process.</p> <p>The CE and clinical manager could describe situations that would require reporting to relevant authorities. The service has reported seven section 31s between March 2017 to February 2017 including changes to governing body, power outage and resident's incidents.</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>There are human resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Nine staff files were reviewed (quality risk coordinator, assistant clinical manager, two RNs, three caregivers, one cook and one maintenance person). All files contain relevant employment documentation including police vetting, references, current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff are able to describe the orientation process and believe new staff are adequately orientated to the service.</p>

		<p>The staff development training coordinator maintain a record of all staff training and is a Careerforce assessor. The service has three Careerforce assessors. The education plan covers all the mandatory education requirements. Registered nurses and caregivers have access to external training which includes clinical education relevant to medical conditions such as the palliative care course. Household staff have the opportunity to complete Careerforce units with three staff currently in training. In-service days delivered on-site by internal and external educators cover mandatory training. Several training days are offered throughout the year ensuring all staff attend. Five RNs are interRAI competent and five will complete training by the end of May 2017. Staff complete competencies relevant to their roles.</p> <p>All 11 caregivers working in the dementia unit have completed the required dementia units. Two casual staff have commenced training and have been employed less than one year.</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>The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical manager and assistant clinical manager are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns.</p> <p>There is a RN on duty for each unit on the morning shift, an RN in the rest home in the afternoon and an RN on afternoon and night shift in the hospital who provide clinical oversight of the rest home and dementia care unit. There are sufficient caregivers on duty and a “floater” available between the units.</p> <p>The hospital unit has the following caregivers on duty for: morning shift - three caregivers on full shift and three caregivers on short shifts; afternoon shift - two full shifts and three short shifts and; two on night shift. The rest home has the following caregivers on duty for: morning shift - one caregiver on full shift and one caregiver on short shifts; afternoon shift - one full shift and one short shifts and; one on night shift. The dementia unit has the following caregivers on duty for: morning shift - one caregiver on full shift and one caregiver on short</p>

		<p>shifts; afternoon shift - one full shift and one short shift and; one on night shift.</p> <p>Residents and relatives state there are adequate staff on duty at all times. Staff state they feel supported by the clinical manager and assistant clinical manager who respond quickly to after-hours calls.</p> <p>The CEO confirmed on interview there are no planned changes for staff or the roster and all staff are planning to stay on with change of company structure.</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>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy.</p> <p>The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the Age Related Residential Contract (ARCC). Exclusions from the service are included in the admission agreement. All nine admission agreements viewed (including respite) 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. A transfer form accompanies residents to receiving facilities and communication with family is made. Respite residents have their discharge recorded in</p>

		the progress notes.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There were no standing orders.</p> <p>The facility uses a sealed pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses administer medications in the hospital. Senior caregivers who have been assessed as medication competent, administer medications in the rest home and dementia unit. Medication competencies are updated annually, and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on an electronic administration signing system, which was installed in March 2017. Eighteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have indications for use charted.</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>The service employs three cooks who between them, cover all shifts. There is also a kitchen hand during the day. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from a bain marie to all dining rooms. Special equipment such as lipped plates is available. On the day of audit, meals were observed to well presented. 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. Kitchen fridge and freezer temperatures are monitored and recorded weekly. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements</p>

		and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is written and approved by an external dietitian. All resident/families interviewed are happy with the meals. Additional snacks are available at all times in the dementia unit.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reason for declining service entry to residents should this occurs 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>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files sampled indicate that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files contain appropriate assessment tools and assessments that have been reviewed at least six-monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. Care plans sampled have been developed on the basis of these assessments.
<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 reviewed evidence multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide sufficient detail to guide care. Residents and relatives state that they are involved in the care planning process.</p> <p>Short-term care plans are in use for changes in health status and are evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist; physiotherapist; dietitian;</p>

		and Mental Health Care Team for Older People. The care staff advise that the care plans are easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All eight long-term care plans sampled have interventions documented. Care plans have been updated as residents' needs changed. The respite resident has an initial care plan documented.</p> <p>Resident falls are reported on accident forms and written in the progress notes.</p> <p>Care staff state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned. There are eight wounds in the rest home (three lesions, three skin tears, one graze and one blister), seven wounds in the hospital (two lesions and five skin tears) and no wounds in the dementia unit. There are no pressure injuries. The facility has access to wound care specialist advice if required.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one diversional therapist (DT) and three activities assistants who cover seven days a week. They work 0900 to 1500 during the week and two to three hours at the weekend. The dementia unit has a dedicated activities assistant for two hours a day. On the days of audit, residents were observed participating in exercises, watching a movie, colouring in and knitting. There was also a van outing.</p> <p>There is a fortnightly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities in which to</p>

		<p>participate. These include: exercises; knitting; walks outside; crafts; games; and quizzes.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are weekly church services and the denominations rotate.</p> <p>There are van outings twice a week. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There was evidence of Easter craft sessions.</p> <p>Some residents attend stroke club and there are visiting community groups such as choirs, children's groups and pet therapy.</p> <p>The young person with a disability resident likes to join in with lots of activities.</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. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The eight long-term care plans reviewed have been reviewed by the registered nurses six-monthly or when changes to care occurs. 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 resident and these have been evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. The family members interviewed confirm that they are informed of any changes to the care plan.</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</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</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>files. There was evidence of where residents had been referred to the dietitian and Mental Health Services for Older People. Discussion with the registered nurse confirms 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. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicate a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person described the safe management of hazardous material.</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 (31st August 2017).</p> <p>There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. All hoists and scales have been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and are within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted. Ensuites, communal showers and toilets have nonslip vinyl flooring. All halls 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 are well maintained. Some courtyards have attractive water features. The dementia unit has a walking pathway, gardens and a small aviary. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>

		The CEO confirmed on interview there are no environmental changes planned in the short term, apart from on-going maintenance and upgrades to furnishings and equipment as needed.
<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	There are two double rooms in the rest home, however, all rooms have single occupancy. Seven rest home rooms have their own ensuite and the remainder have shared ensuites. Twelve hospital rooms have an ensuite and the remainder share ensuites. In the dementia unit, all rooms share communal showers and toilets. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are well maintained and easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors.
<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	Residents' rooms are spacious and allow care to be provided and the safe use of mobility aids. Staff report that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. Some lounges open out onto attractive courtyard areas. There are spacious dining rooms in each wing.
<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	Laundry is contracted out. There is a laundry on-site, but this is only used for personal clothing which has not yet been named. The laundry is divided into a "dirty" and "clean" area. There is a comprehensive laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners'

		room as sighted on the day of the audit. Cleaning is done by on-site cleaners. There are two sluice rooms for the disposal of soiled water or waste. The sluice room and the laundry are kept closed when not in use.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation. A civil defence storage room includes supplies (torches/batteries, gas bottles, resident information including identification bracelets) and pandemic supplies all of which are checked six-monthly. Three generators were purchased following a power outage in 2016 (Section 31 submitted). There is sufficient water (four 600 litre header tanks and bottled water) and food for at least three days. Barbeques and gas bottles are available for alternative cooking.</p> <p>The fire evacuation scheme was approved by the fire service. Six-monthly fire drills are completed. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells which are linked to pagers worn by staff. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. Security camera surveillance has been installed within the last year.</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 bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff stated that this is effective. The facility has a small outside smoking area by the garden shed. All other areas are smoke free.</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</p>	FA	<p>The infection control coordinator is the assistant clinical manager who has been in the role seven years. She is currently mentoring a RN who has completed an infection control course. The infection control coordinator oversees infection control for the facility and is responsible</p>

<p>appropriate to the size and scope of the service.</p>		<p>for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the quality & risk meeting, RN & caregiver meetings.</p> <p>The 2016 infection control programme has been reviewed in consultation with the trustees, clinical manager and infection control team and is linked to the quality system.</p> <p>Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has attended external infection control and prevention education annually, including DHB infection control nurse meetings.</p> <p>The combined Infection Control/Health and Safety Committee form part of the Quality Risk Committee and consist of representatives from each service area. The committee meets two-monthly and discuss infection control events and quality data as evidenced in meeting minutes. The meeting agenda includes developing and reviewing the infection control quality goals.</p> <p>The infection control coordinator has access to GPs, local laboratory, the infection control nurse specialist at the DHB and public health departments at the local DHB for advice and an external infection control consultant specialist.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, 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 are reviewed regularly (last February 2017) by the infection control coordinator using a reference manual developed by an external infection control specialist.</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>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand washing competencies are completed on orientation and are ongoing.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</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>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information including graphs are displayed on the staff noticeboard in the staff office. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the Infection Control/Health and Safety and Quality Risk Committee meetings and clinical meetings. Trends are identified, and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. The services participate in the Far Northland benchmarking group who have set key performance indicators (KPI) around infection rates. Action plans are developed for any infection rates above the KPI.</p> <p>There is close liaison with the GP that 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.</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. On the day of the audit there were seven hospital level residents with restraints in use (four residents had two restraints) and two hospital residents with bedrails as enablers.</p>

		<p>Resident files reviewed for enabler use (two) identified the resident had given voluntary consent.</p> <p>The CEO on interview stated that management and staff are not changing. The directors will support the staff to maintain their responsibilities in respect of restraint minimisation and safe practice.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A registered nurse (also the quality risk coordinator) is the restraint coordinator with a defined job description. Restraint discussion and quality data around restraint and enabler use is included in the quality/risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours. Staff complete restraint competencies.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, the resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form had been completed for three resident files reviewed requiring restraint (sighted). Assessments identify risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the three care plans reviewed. Individual restraint monitoring booklets</p>

		evidence checks, and cares have been carried out according to the documented frequency described in the resident care plan and monitoring tool. There is an up-to-date restraint register.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluations occur six-monthly as part of the ongoing review for residents on the restraint register and as part of their care plan review. Families (where possible) and the GP and RNs are included as part of this review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage is monitored regularly. The review of restraint use is discussed at the quality risk meetings and relevant facility meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed six-monthly and demonstrate compliance of the standard.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	<p>There is a 2017 quality plan with goals around training, reporting of accidents/incidents and near misses. Staff are encouraged to report near misses with the monthly goal of seven reports per month. The hazard register has been reviewed, risk ratings changed and visual risk calculators available in all areas. The service reviewed the staff induction around health and safety training has been improved to increase staff understanding and awareness around safe manual handling.</p>	<p>All staff attend an induction day which covers: health and safety; risk management; hazard management; and safe manual handling for care staff. The orientation package around health and safety has been reviewed and includes health and safety questionnaires that are easily understood.</p> <p>The service identified that the reporting of near misses was an area to improve as they did not feel they were accurately collecting the service risk without including near misses. Accident/incident/near miss forms are titled 'OSH-IT!!' Forms have a positive impact on the reporting of near misses. This has assisted in the service meeting the monthly target of near misses which have now been included in the review of the hazard register.</p> <p>Each area of the care facility has an up-to-date hazard register specifically related to resident care. Care staff</p>

			<p>interviewed described where to find the hazard register.</p> <p>The service has produced its own video on hazards related to transfer of residents using staff to demonstrate safe manual handling including the use of a hoist. The video is well produced and uses a village resident (once an actor) to be the compere. The video has resulted in a 90% increase in staff awareness (taken from questionnaires and staff feedback) around resident transfers. The service now aims to produce further videos around safety and hazard management.</p> <p>Staff induction/updates on health and safety are taken monthly with groups of 16-20 watching the video and completing questionnaires. The auditor viewed the video and commended the risk management team for its innovative way to increase staff awareness around health and safety.</p>
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End of the report.