

Lifecare Funds Limited - Kolmar Lodge 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 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:	Lifecare Funds Limited
Premises audited:	Kolmar Lodge Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 August 2018 End date: 10 August 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:	17

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

Kolmar Lodge Rest Home is privately owned and operated, and provides care for up to 26 residents requiring rest home level care. On the day of the audit there were 17 rest home residents.

The service is managed by an operations manager who has worked at the facility for ten years and reports to the two managing directors. The operations manager is supported by an assistant manager/activities coordinator and RN. Residents and families interviewed were complimentary of the care and support provided. Staff turnover remains low.

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

There were no areas for improvement identified at this audit.

The service is commended for achieving a continuous improvement rating around infection surveillance.

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.

The staff at Kolmar Lodge Rest Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

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

Standards applicable to this service fully attained.

The quality and risk programme describes Kolmar Lodge Rest Home's quality improvement processes. Progress with the quality and risk management programme is monitored through the bi-monthly integrated meeting and bi-monthly staff meeting. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is a current business plan in place. Resident/relative meetings are held three monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The internal audit schedule for 2017 has been completed and 2018 has commenced.

The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the general practitioner. The activities coordinator implements 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. All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals and baking provided. Snacks are available on request.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. Two single rooms and one double have ensuites and there are sufficient communal showers/toilets for all other rooms. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Kolmar Lodge Rest Home has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training in restraint minimisation and challenging behaviour management.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		All standards applicable to this service fully attained with some standards exceeded.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The operations manager is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information

obtained through surveillance is used to determine infection control activities and education needs within the facility. A quality project has seen a reduction in the number of urinary infections. There have been no outbreaks since the last audit.

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	1	44	0	0	0	0	0
Criteria	1	92	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with five care staff, including one assistant manager/activities coordinator, one registered nurse (RN), two caregivers and one cook confirmed their familiarity with the Code. Five residents and two family members interviewed confirmed the services being provided are in line with the Code. Staff have received training on the Code in June 2018.
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	The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (five rest home (including one long-term support chronic health care). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. There were advanced directives on all resident files reviewed. The operations manager stated that they ask for these to be completed on admission if the resident is competent to sign.

<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>Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to 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>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.</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>There have been no complaints made since the last audit in December 2016. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Two caregivers interviewed were able to describe the process around reporting complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code and advocacy pamphlets are located at the main entrance of the service. On admission a manager or RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are informed about the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Staff receive training on abuse and neglect, which was last completed in August 2018.</p>

a manner that has regard for their dignity, privacy, and independence.		
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were six residents that identified as Māori. The files of two residents that identified as Māori were reviewed and included Māori cultures and preferences. Māori consultation is available through a local kaumātua who visits on a regular basis. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training on cultural safety and Treaty of Waitangi.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged.</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 staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There is a monthly in-service education and training programme for staff, which includes regularly assessing staff competencies. Community outings are encouraged and include regular visits to local cafés, parks and shopping. Residents are supported to safely maintain their independence. All residents and family member interviewed expressed their satisfaction with the care delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Residents and relatives interviewed confirmed that management and staff are approachable and available. Twelve</p>

provide an environment conducive to effective communication.		accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.
<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>Kolmar Lodge Rest Home is owned and operated by Lifecare Funds Limited. It is one of three aged care facilities owned by two managing directors. The service provides care for up to 26 rest home level residents. On the day of audit there were 17 rest home level residents at the facility including two residents under the LTS-CHC contract (both residents were under the age of 65). There were also three private paying boarders living in the facility.</p> <p>There is a 2016-2018 business plan in place that is reviewed annually. The plan outlines objectives for the period that includes increasing occupancy rates to 96%, upskilling staff, ongoing maintenance/building plan, complying with the national standards and maintaining relationships with the district health board (DHB), families, local communities and residents.</p> <p>An operations manager (also a RN), reports to the managing directors and is supported by an assistant manager/activities coordinator and an RN. The operations manager has been in the role for ten years and works on a full-time basis across the three facilities. The majority of her time (25 hours) is at Kolmar Lodge Rest Home. She is also a qualified diversional therapist and in addition to her responsibilities as operations manager, she is responsible for oversight of the activities programme at all three facilities. The RN has been in the role for two months and has appropriate experience to meet the clinical needs of the residents.</p> <p>The operations manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The operations manager reported that in the event of her temporary absence, the assistant manager/activities coordinator fills the role with support from the RN and care staff.</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>	FA	<p>The quality and risk management programme describes Kolmar Lodge Rest Home's quality improvement processes. Quality data and outcomes are taken to the bi-monthly integrated committee meetings and then on to the bi-monthly staff/meetings. Meeting minutes demonstrate key components of the quality management system, including internal audit, infection prevention and control, incident/accidents data and in-service training/education. The internal audit schedule for 2017 has been completed and 2018 is being completed as per schedule. Areas of non-compliance identified at audits have been actioned for improvement. Meeting minutes reviewed indicate issues raised are followed through and closed out, including three-monthly resident/relative meetings. Issues arising from internal audits are reported on the audits action sheet and were sighted to have been closed out. An annual resident and relative satisfaction survey (September 2017) has been conducted with respondents advising that they are overall very satisfied with the care and service they receive. Residents and relatives have been informed of the survey results.</p> <p>There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies have been developed by an aged care consultant and are reviewed and updated two yearly. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system is in place to manage policies and procedures. There is a health and safety and risk management programme in place including policies to guide practice. The operations manager is the health and safety officer. Staff accidents and incidents and identified hazards are monitored. Hazard identification forms and an up-to-date hazard register (last reviewed 17 July 2018) are in place. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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>There is an incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms for the month of June and July 2018 were reviewed. All document timely RN review and follow-up. Neurological observation forms were documented and completed for seven unwitnessed falls or with potential head injury. There is documented evidence the family had been notified of any incidents. Discussions with the operations manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been one section 31 notification lodged since the last audit relating to a missing resident in November 2017.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files (one operations manager, one assistant manager/activities coordinator, one RN, one</p>

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>caregiver and one cook/caregiver) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. A current practising certificate was sighted for the operations manager and RN.</p> <p>The service has an orientation programme in place to provide new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The RN and caregivers' complete competencies relevant to their role such as medications. The service has an annual training schedule for in-service education that covers compulsory education requirements over a two-year period. The operations manager has completed interRAI training and the RN is in progress of completing.</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>	FA	<p>Kolmar Lodge Rest Home has a fortnightly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The operations manager works full-time across the three facilities with the majority of her time (25 hours) at Kolmar Lodge Rest Home. The operations manager lives on-site at Kolmar Lodge Rest Home and is available on call 24/7. There is an RN on-site for 32 hours per week (Tuesday to Friday) or more if required. The assistant manager/activities coordinator works full time from Monday to Friday.</p> <p>The local GP also provides after hours care if required and the caregivers have access to the local ambulance service. The operations manager, assistant manager/activities coordinator and RN are supported by three caregivers (one long and two short shifts) on duty in the morning shift, two caregivers on duty in the afternoon shift and one caregiver on the night shift. Roster shortages or sickness are covered by casual or off duty staff. The caregivers and residents interviewed reported that there is sufficient staff cover.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC contract. Exclusions from the service are included in the admission agreement. All five admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on-site. The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are administered by the RN or senior medication competent caregivers.</p> <p>Medication education has been completed in the last year. The medication fridge temperature is checked daily. There are currently no eye drops but the RN stated that these would be dated once opened. Staff sign for the administration of medications on a paper signing sheet. Ten medication charts were reviewed (including one long-term support chronic health care). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had 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 has one cook who works a split shift 7.00 am -1.00 pm and 3.00 pm - 4.00 pm Tuesday to Saturday. Another cook covers Sunday and Monday. Both 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 the kitchen to the dining rooms. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a</p>

		<p>range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance.</p> <p>Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements 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 were noted in a folder. The four-weekly menu cycle is approved by a dietitian. Māori residents had recently had a 'boil up' for Matariki. Snacks are available on request. All residents and family members interviewed were satisfied with the meals. The food control plan was approved on 4 July 2018.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all five residents whose files were sampled. Other assessment tools in use were falls risk, pressure injury risk, pain and depression. Care plans sampled were developed on the basis of these assessments.</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 reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist (one chronic wound) and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow, and guidelines were clear.</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>When a resident's condition changes, the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their head. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently two wounds being treated. One chronic wound (non-facility acquired) has had input from the GP and wound care specialist. At the time of the audit there were no pressure injuries. 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>The operations manager is also a diversional therapist and she oversees the activities programme. There is also an activities coordinator (assistant manager) who works 9.30 am to 3.00 pm from Monday to Friday. There are volunteers who come in at weekends. On the day of audit residents were observed playing bingo, answering a quiz and watching TV. There is a weekly programme in large print on noticeboards in the lounges and hallways. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, movies with popcorn and walks outside. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. Most residents were out of their rooms. There is a weekly interdenominational church service held in the facility. There are no Catholics at present, but the local priest visits when there are.</p> <p>There are weekly van outings. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day the Melbourne Cup and Matariki are celebrated. The Māori residents enjoyed a 'boil up' to celebrate Matariki. A pet therapy team visits every Wednesday. There is community input from the RSA and a local Kaumātua. Residents like to visit the local plaza and the night markets. Younger residents go out more often; shopping, swimming, picnics and movies. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held three monthly.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The five long-term care plans reviewed had been evaluated by the RN 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 of the residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family member interviewed confirmed 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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the RN identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. One sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	FA	<p>The building holds a current warrant of fitness which expires 16 March 2019. There is a maintenance person on-site for 30 hours a week. Contractors are used when required. Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted in one area and vinyl in another. The utility areas such as the kitchen and laundry have vinyl</p>

facilities that are fit for their purpose.		<p>flooring.</p> <p>Residents' rooms are carpeted, and communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home level of care residents.</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 two single rooms with an ensuite and one double. All other rooms share communal showers and toilets. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are privacy signs on all shower/toilet doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 24 single rooms and one double. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported 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>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are where residents who prefer quieter activities or visitors may sit. There is one medium sized and one small dining room.</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>Laundry is done on-site by caregivers on a rostered system. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All cleaning chemicals were labelled. There is no sluice room. Disposal of soiled water and the sluicing of soiled linen are completed in the ‘dirty’ area of the laundry if required. The laundry is kept closed when not in use.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service on 3 November 2005. There is an emergency/disaster management plan in place. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 31 May 2018. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including sufficient food, water, blankets and alternate gas cooking (BBQ).</p> <p>There are civil defence and first aid kits available that are checked six monthly. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The operations manager and RN hold current first aid certificates. There is a call bell system in place and there are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is gas. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents smoke. 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</p>	FA	<p>The operations manager has responsibility for infection control across the facility but is ably assisted by an infection control committee. Responsibility for infection control is described in the job description. The operations manager oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by the infection control committee. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no</p>

consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		outbreaks since the last audit.
<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>	FA	The operations manager has been in the role of infection control coordinator for many years and is very experienced. She has access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.
<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	The infection control policies include a range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the infection control coordinator and the infection control committee, with input from infection control experts from the DHB.
<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	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have completed hand hygiene audits and have participated in group infection control education projects which are displayed on the staff noticeboards when completed. The current display is on prevention of urinary tract infections. Resident education occurs as part of providing daily cares and as applicable at resident meetings. Last year there was emphasis on prevention of urinary tract infections and this year hand hygiene.

<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>	CI	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed at infection control committee and staff meetings. Meeting minutes including graphs are available to staff. Trends are identified and analysed, and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Kolmar Lodge Rest Home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint free environment. Staff receive training in restraint minimisation and challenging behaviour management.</p>

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, there 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
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and	CI	In 2017 results of surveillance led the IC coordinator and the IC committee to conclude that the number of urinary tract infections (UTIs) they had, was relatively high for the number of residents, 25 in 2016. They initiated an IC quality project with emphasis on the prevention of UTIs. There was an intensive staff and resident education programme which focused on resident hygiene, increasing resident fluid input and resident, and staff hand washing. Each month, statistics were posted on the staff noticeboard and staff took great pride in any reduction. Their goal was to decrease UTIs by 40%. The outcome achieved was a 50% reduction as the number of UTIs in 2017 was ten. So far in 2018 there have been three UTIs. They continue to post statistics on the staff noticeboards and there is continued emphasis on education.	In 2017 results of surveillance led the IC coordinator and the IC committee to conclude that the number of urinary tract infections (UTIs) they had, was relatively high for the number of residents, 25 in 2016. They initiated an IC quality project with emphasis on the prevention of UTIs. There was an intensive staff and resident education programme which focused on resident hygiene, increasing resident fluid input and resident, and staff hand washing. Each month, statistics were posted on the staff noticeboard and staff took great pride in any reduction. Their goal was to decrease UTIs by 40%. The outcome achieved was a 50% reduction as the number of UTIs in 2017 was ten. So far in 2018 there have been three UTIs. They continue to post statistics on the staff noticeboards and there is continued emphasis on education.

management in a timely manner.			
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End of the report.