Karaka Court Limited - Woodlands of Palmerston North

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:	Karaka Court Limited
Premises audited:	Woodlands Of Palmerston North
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 August 2018 End date: 17 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: 25

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

Woodlands of Palmerston North is one of two facilities owned by Karaka Court Ltd. Woodlands of Palmerston North provides care for up to 38 residents at rest home and secure dementia level of care. On the day of audit there were 25 residents.

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

The service has a mission, business goals and quality goals that support the service goals of a family friendly service.

The service is managed by a non-clinical manager and a clinical nurse leader. Residents and relatives interviewed spoke positively about the service provided.

There is an improvement required around staff appraisals and dementia standards training.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Data is collected, analysed and discussed, and changes are made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified. Residents receive appropriate services from suitably qualified staff. An orientation programme is in place for new staff. There is an annual education and training plan that exceeds eight hours annually. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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.

The service has a well-developed assessment process and resident's needs are assessed prior to entry. Assessments, care plans and evaluations are completed by the registered nurse. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services.

The diversional therapist provides an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The service medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food that was provide.

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.

Chemical safety is maintained. There is adequate equipment provided to ensure the needs of residents are met and suitable equipment to provide care is available. The building holds a current warrant of fitness. A maintenance prevention programme is implemented. Electrical equipment is checked annually. There are a number of communal lounges and dining areas. There are documented laundry services policies/procedures. There is a plentiful supply of protective equipment, gloves, and aprons. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan. The facility has civil defence kits and emergency management plans.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit there were no residents with a restraint and no residents using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous 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	0	44	0	1	0	0	0
Criteria	0	92	0	1	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	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with five care staff (three caregivers, one registered nurse (RN) and one diversional therapist) confirmed their understanding of the Code. Four rest home residents and three rest home relatives, confirmed that staff respect privacy and support residents in making choices.
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	Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the five resident files (two dementia and three rest home level residents including one respite who became long-term on day of audit). Caregivers and the registered nurse interviewed, confirmed consent is obtained when delivering cares. Resuscitation orders had been appropriately signed by the resident and general practitioner (GP). The service acknowledges the resident is for resuscitation in the absence of a signed directive. Copies of the enduring power of attorney was available in three of the five files reviewed. The two without were fully competent. Discussion with family members identifies that the service involves them in decisions that affect their relative's lives. Admission agreements for permanent residents

		and the short-stay resident were sighted.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed, confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on resident's family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting hours. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the service. Residents interviewed confirmed they received information on the complaints process on admission and the manager is very approachable should they have any concerns/complaints. Care staff interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There has been one complaint documented for 2018. This complaint had been followed up and responded to appropriately.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The RN or manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	A tour of the premises confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Caregivers could describe definitions around abuse and neglect that align with policy, promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers could describe how choice is incorporated into resident care.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The Māori health plan references local Māori healthcare providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The director's family is Ngati Ruanui. During the audit, there were no residents who identified as Māori living at the facility.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met, and family/whānau are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of an employment agreement that covers a code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional when carrying out their duties. Interviews with care staff described how they build a supportive relationship with each resident. Residents and the relatives interviewed stated they are treated fairly and with respect by staff.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. An in-service training programme is implemented as per the training plan. The staff are committed to providing a service based on the mission statement and philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. Facility meetings and shift handovers

		enhance communication between the teams and provide consistency of care. The service has documented a monthly falls map on the staff noticeboard, which identifies time and location of falls, this has increased staff awareness of falls. Falls in the dementia unit have reduced. The service has also implemented a new care plan template that links to interRAI and an improved internal audit system.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident/accident into the system. Six incident/accident reports reviewed met this requirement (two from the dementia unit and four from the rest home). Resident files reviewed, documented family communication. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Woodlands of Palmerston North provides care for up to 38 residents at rest home and secure dementia level of care. On the day of audit there were 14 rest home residents (plus three boarders) and eight residents in the dementia unit. There was one rest home resident on respite care at the time of the audit. All other residents were under the ARC contract. The two company directors of Karaka Court Ltd operate two facilities, Woodlands of Palmerston North and Feilding. The service has a mission, business goals and quality goals that support the service goals of a family friendly service. There is a 2016 - 2018 business plan, a quality and risk plan for 2016 -2018 and operational quality goals. Goals are followed up through meetings and formal review. The service is managed by an experienced manager (non-clinical) who has been in the post for ten years. She reports to one of the directors monthly and is supported by a clinical leader/RN who works full time Monday to Friday. The clinical leader has been in her role for three years. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home (sighted). An experienced quality systems manager (RN) also supports the service.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is	FA	The clinical leader covers during the temporary absence of the manager with support from the quality systems manager and the director.

managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings. Discussions with the managers reflected staff involvement in quality and risk management processes. Resident meetings are completed monthly. Meeting minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. The 2017 resident/family survey reflected that 11/15 surveyed were very satisfied with the service. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies have been reviewed at least bi-annually and include procedures around the implementation of interRAI. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. There are clear guidelines and templates for reporting. The facility collects, analyses and evaluates data. This is utilised for service improvements. Action plans are developed when service shortfalls are identified and followed up until rectified by the quality systems manager and through meetings. Health and safety policies are implemented and monitored by the manager. The health and safety committee meet monthly as part of the monthly quality/staff meeting. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of six incident/accident forms (two dementia level and four rest home level) identified that forms were fully completed and include follow-up by

the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		the clinical leader. Neurological observations are completed for any suspected injury to the head. The clinical leader and manager are involved in the adverse event process. The manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (the manager, clinical leader, three caregivers, and one activities person) included a recruitment process, which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. Health practitioner practising certificates are maintained on file. The orientation programme provides new staff with relevant information for safe work practice. There is a two-yearly education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. The clinical leader is interRAI trained. Not all staff who work in the dementia unit have undertaken the dementia standards training and not all staff appraisals are up to date.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. The clinical leader (RN) and the manager (non-clinical) are on-site Monday to Friday. The clinical leader is on-call 24/7 when not on-site. Caregiver rosters are as follow: Dementia unit: - 8 residents AM: two caregivers on full shifts, PM one caregiver on a full shift and one caregiver on short shift and one caregiver on night shift. Rest home – 17 residents. AM two caregivers on full shifts and one caregiver on short shift. PM caregiver on long shift and one caregiver on short shift and one caregiver on night shift. Caregiving staff are responsible for laundry. Cleaning staff work five days a week, four hours a day. Staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family interviewed, advised that they felt there is sufficient staffing.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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. Entries are legible, dated and signed by the relevant caregiver or clinical leader including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical leader screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager or clinical leader. The admission agreement form in use, aligns with the requirements of the ARC contract and exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. Records are kept with the residents' files. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The service uses robotic medication packs and an electronic charting system. Medications are checked on arrival by the clinical leader and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely. Staff sign for the administration of medications on the electronic system. There were no expired medications in the medication cupboard or in the fridge. Controlled medication balances are checked weekly. The clinical leader or senior caregivers administer the medication in both areas. Annual medication competencies are completed. The clinical leader advised there were no residents self-medicating on the day of audit. The service has in place policies and procedures for ensuring all medicine related recording and

		documentation meets acceptable good practice standards. The medication fridge is monitored daily (records sighted). Allergies were evident in all 11 medication charts reviewed and medication orders record indication for use for 'as required' medication (PRN).
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a large workable kitchen with three cooks rostered over the week, so one is on each day. All have completed food safety training. All residents have a nutritional and hydration care requirement developed on admission, which is reviewed at the six-monthly review. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. There is a summer and winter menu. The menu rotates four weekly and is designed and reviewed by a registered dietitian (January 2018). Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving. There is evidence that there are additional nutritious snacks available in the unit over 24 hours for dementia residents. The kitchen, kitchen equipment and kitchen staff can meet the needs of the residents. There is an approved Food Control Plan which expires July 2019. Equipment is available on an as needed requirement. Residents requiring extra assistance to eat, and drink are assisted by caregivers and were observed during lunch.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The service records the reason for declining service entry to residents, should this occur and communicates this decision to residents/family/EPOA. Anyone declined entry is referred to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely	FA	Comprehensive multidisciplinary assessments were completed in files sampled. All files reviewed had appropriate assessments on admission. Needs, outcomes and goals of residents were identified through the assessment process in the files sampled. Residents and family are consulted, and agree to intervention outcomes. The clinical leader has completed interRAI training. There was evidence of interRAI assessments being undertaken six monthly. A request had been

manner.		forwarded for the interRAI assessment for the resident who went from respite to long-term care on day of audit.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans sampled, document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and demonstrate input from allied health. The respite resident file documented care and support for the short-stay and was being transferred to a long-term resident on the day of audit. Short-term care plans are in use for changes in health status. STCPs were viewed for skin tears, nose bleed, weight loss, infections and falls.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation reviewed and interviews with staff, residents and relatives identified that the care that is being provided is consistent with the needs of residents. Monitoring charts and behaviour monitoring charts were sighted in files sampled. Residents' needs are assessed prior to admission. The service has residents under nine GPs at present. One GP who covers ten residents (or their nurse practitioner) visit weekly or as required. There is an afterhours service available from a local practice. During the tour of the facility it was noted that all staff treated residents with respect and dignity. Dressing supplies are available, and a treatment room/cupboard is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. There were no residents with wounds. There were no pressure injuries. The clinical leader interviewed, described the assessment, plan and evaluation should there be a wound and the referral process should they require assistance from a wound specialist.
Standard 1.3.7: Planned Activities 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.	FA	There is a qualified diversional therapist (DT) that provides activities in the rest home and the dementia unit. Two separate monthly activity programmes are developed, one for the rest home and one for the dementia unit. The DT works forty hours per week Monday to Friday. On the day of audit, residents were observed being actively involved with a variety of activities in the rest home and in the dementia unit. All residents are given a weekly plan, and plans are evident in a prominent place for viewing in each unit. Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a complete history of

		past and present interests, career and family. Activities are age appropriate and are planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. The facility van goes out three times a week taking residents for drives and events in the community. These include outings to Friendship Club and Senior Citizens. Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff through residents' meetings or following activities. Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by the clinical leader six monthly or when changes to care occurred. Evaluations were documented and included progress to meeting goals. There was documented evidence of care plans being updated as required. There is at least a three-monthly review by the GP. There are short-term care plans to focus on acute and short-term issues and these are reviewed and signed off when resolved.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Discussions with the clinical leader identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The waste management policy and procedure outlines processes. Staff were observed wearing appropriate protective clothing. All chemicals sighted were appropriately stored in locked areas and fully labelled. There is an incident reporting system that is in use. A comprehensive emergency plan is available to staff which includes hazardous substances.
Standard 1.4.2: Facility Specifications	FA	There was a current building warrant of fitness sighted, which expires on 4 April 2019. The facility

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		is maintained in good order with regular maintenance and refurbishment. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person. Electrical appliances that are not permanently wired are checked annually by a contracted service. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. The secure dementia has a separate lounge and dining area, which were both well-supervised on the day of audit. There is a secure outside/garden area. The external areas are well maintained and residents in both wings have access to gardens and indoor areas with ease.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	Residents in both units share communal bathrooms and toilets within their unit. There were sufficient numbers of resident communal bathrooms and toilets near resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity were maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. The resident rooms are of sufficient size to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed, reported that rooms have adequate space to allow cares to take place.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their	FA	The communal areas are easily and safely accessible for residents. There are lounge areas and separate dining rooms, and small seating areas by the reception. The dementia unit has a lounge area and separate dining area. The main dining room was spacious and located directly off the kitchen/server area. The furnishings and seating are appropriate for the resident group. Residents interviewed reported they were able to move around the facility, and staff assisted them when required. Activities take place in any of the lounges.

relaxation, activity, and dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The facility is cleaned by rostered cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed, were satisfied with the standard of cleanliness in the facility. Bed linen is sent to a commercial laundry for processing and the balance of laundry is done on-site in the commercial laundry by caregivers. Residents and relatives interviewed were satisfied with the laundry service. The laundry and cleaning services are able to cater to the needs of rest home and dementia level residents.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency and disaster policies and procedures are in place. Fire evacuation drills take place every six months. The orientation programme and education and training programme includes fire and security training. Staff who are unable to attend complete competency questionnaires. Staff interviews confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan is in place. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and the availability of a gas BBQ. A back-up battery for emergency lighting is in place. A call bell system is in place, suitable to meet the needs of the residents. The call bell system was hard to hear in parts of the dementia unit when music or television was on. This was remedied on the day of audit by installing a light that could be viewed by staff that came on when a call bell was pressed. Residents reported their call bells are answered in a timely manner. There is a minimum of one person rostered on each shift with a current first aid/CPR certificate. External lighting is adequate for safety and security. Doors are locked at dusk.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained	FA	All bedrooms and communal rooms have an opening window to the outside. Electric heaters thermostatically controlled in each bedroom ensure warmth; all areas were warm and well ventilated. There is underfloor heating in the dementia unit plus radiators. Residents and family interviewed stated the environment was warm and comfortable.

at a safe and comfortable temperature.		
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Woodlands has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control nurse with support from the quality systems manager. The quality/staff meeting team is the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme was last reviewed in May 2018.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The clinical leader is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the quality systems manager and have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education has occurred for staff. The infection control nurse has completed infection control training. Visitors would be advised of any outbreaks of infection and advised not to attend until the outbreak has been resolved. There have been no outbreaks. Information is provided to residents and visitors that is appropriate to their needs and this is

consumers.		documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Woodlands' infection control manual. Systems in place are appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit there were no residents with a restraint and no residents using an enabler. Staff training is in place around restraint minimisation and management of challenging behaviours.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The service has implemented a two-yearly education plan and training sessions are well attended by staff. Caregivers interviewed stated they receive a wide range of education subjects. Not all staff who work in the dementia unit have completed the dementia standards within the set timeframes, and appraisals are not documented annually for all staff.	(i)Of the 12 staff who work in the dementia unit, five had not completed the dementia unit standards within the set timeframes. (ii) Of the six staff files reviewed, four did not have an annual appraisal documented.	(i)Ensure that staff who work in the dementia unit complete the dementia standards within set timeframes. (ii) Ensure that all staff have a documented staff appraisal at least annually. 90 days

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.

No data to display

End of the report.