Alaama Care Limited - Turama House 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 The DAA Group 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:	Alaama Care Limited
Premises audited:	Turama House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 October 2018 End date: 5 October 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: 27

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

Turama House Rest Home provides rest home level care for up to 36 residents. The service is one of three facilities owned and operated privately by the same directors. The owner manager oversees all non-clinical aspects of service at Turama House Rest Home. Clinical care is overseen by a registered nurse manager who also works at a facility owned and operated by the same company. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, a doctor from the Mental Health Services for the Older Adult (MHSOP) and a general practitioner.

This audit has resulted in a continuous improvement in medication management. No areas requiring improvement were identified.

Consumer rights

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

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The owner/manager visits the facility daily and monitors all services provided. A nurse manager who holds a current annual nursing practising certificate is experienced and suitably qualified to manage all clinical aspects of service.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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.

The facility meets the needs of residents and was clean and well maintained. There have been multiple environmental upgrades undertaken over the past 12 months. There is a current building warrant of fitness. Electrical and medical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Staff maintain security.

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 organisation has implemented policies and procedures that support a restraint free environment. No enablers or restrains were in use at the time of audit. Should restraint be required, policy contains a comprehensive assessment, approval and monitoring process which was understood by the restraint coordinator and staff. Policy identifies that the use of enablers is voluntary for the

safety of residents in response to individual requests. Restraint education is undertaken as part of staff orientation and annually thereafter.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	45	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	The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. The nurse manager interviewed stated that there are 20 residents currently with an advance care plan. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. An advocate from the Health and Disability Commissioner's service visits annually and has recently met with residents and attended the residents meeting in September 2018 to discuss their role.
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	All residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Residents interviewed stated that they are encouraged when leaving the premises to sign in and sign back into the facility. All residents have also been supported by facility staff in safe road crossing of the busy street accessing the local shopping centre. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family and residents' friends interviewed stated they felt very welcome when they visited and comfortable in their dealings with staff also having the option of visiting their family/friend in one of three lounges and had access to different outside settings other than the resident's bedroom.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that three verbal complaints have been received over the past 10 months since the current owner purchased the business, and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The nurse manager is responsible for complaints management and follow up includes the owner/managers signoff. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There was one complaint received via the Health and Disability Commissioner open when the business was purchased. It was opened on the 19 July 2017. Documentation identifies that the current owner has responded to all required issues and that the complaint was closed on the 25 May 2018. The information sent to the Health and Disability Commissioner included evidence of a current medication policy which reflected residents' self-administration of medications management practices and that all staff who administer

		medications hold a current competency to do so. This was confirmed in documentation sighted. The current owner/manager has received no complaints from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service). Residents and family have been provided with an information pack at the time of admission along with an admission agreement, and further information is provided in day to day discussions with staff. The Code is displayed throughout the facility and each of the resident's bedrooms. The main foyer and the two lounge areas provide information on advocacy services and how to make a complaint and feedback forms are provided.
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	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan for all ages. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
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	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The nurse manager interviewed reported that there is one resident who affiliates with their Māori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is a specific current Māori health plan and all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and integrated into long-term care plans, along with information about kai (food), rongoa (medicine management), taonga (valuables) and tupapaku (instructions having passed away). There is also an acknowledgement of the family spokesperson the resident has appointed. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Whanau were not available for interview, however the Māori resident interviewed reported that staff acknowledge and respect

		their individual cultural needs.
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	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example food and personal grooming/dressing preferences. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, psychogeriatrician, physiotherapist, stoma nurse, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included staff being very aware of residents' routines and personal preferences, the knocking on doors before entering rooms and day to day discussions.
Standard 1.1.9: Communication Service providers	FA	Residents of all ages and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff

communicate effectively with consumers and provide an environment conducive to effective communication.		understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The facility has a mixed cultural and ethnic population of residents. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed and the support of family members. There was one resident who has a significant sensory impairment. All resources and equipment were available for the resident, for example support from community resources and the knowledge that the staff had of the resident and the equipment/aid. All interventions and required support were sighted in the resident's long-term care plans.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The quality, strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and goals, and the associated operational plans. The owner/manager spends part of each day at Turama House Rest Home and attends staff monthly meetings. She discusses all issues and concerns with the nurse manager via email, telephone or face to face and monitors all service delivery at the facility. The owner/manager is directly responsible for financial management, human resources and environmental matters. The nurse manager informs the owner/manager of all quality data trending, corrective actions, quality initiatives, emerging risks, and resident status. The current owner/manager purchased the facility on the 06 December 2017. She owns three facilities and has worked in the aged care industry for ten years. The nurse manager who has been in the role since purchase of the facility also oversees clinical services at a nearby sister facility. She completed a Post Graduate Degree in Advanced Nursing in 2017. Both managers hold relevant qualifications and attend appropriate ongoing education, such as accounting, payroll, elder abuse and stoma care, and they attend Auckland District Health Board (ADHB) training and meetings as required. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Both members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements. The service holds contracts with Auckland District Health Board (ADHB), and the Ministry of Health (MoH) for rest home level care including respite, chronic health conditions and residents under the age of 65 years. On the day of audit there are 27 rest home level care residents at Turama House Rest Home. Twenty-two residents were receiving services under the ADHB – Age Related Residential Care contract, three residents were under the ADHB - Long Term Support Chronic Health contract and two residents were under the MOH – Non-Aged Residential Care contract at the time of audit. There are six boarders living at the facility who are either private paying or funded via alternative means and not from the health budget. These six people were not included in the resident numbers audited in this report.

		ADHB are aware of the boarders and two of the current boarders have been referred from the DHB. The facility actively manages the boarders. One has been referred to the needs assessment agency for re-assessment to rest home level care, two boarders and their families are looking for alternative care with the assistance of the nurse manager and one boarder is going back to their own home on 28 October 2018 with community support service assistance and the move will be overseen by a social worker from ADHB. The service had a dispensation for one resident to be hospital level care which expired in May 2018. The resident has been moved to a hospital level care facility and the dispensation no longer applies.
Standard 1.2.2: Service Management 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.	FA	When the owner manager is absent, the nurse manager carries out all the required duties under delegated authority, as sighted in documentation. During absences of key clinical staff, the clinical management is overseen by a registered nurse from a sister facility who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.
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	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections, wounds, falls and pressure injuries. Meeting minutes reviewed and interviews with management confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management daily catch-up, at the monthly management meeting and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. One example relates to a corrective action put in place to ensure that residents who have a personal fridge in their rooms, have the temperature monitored daily. Completed daily monitoring documentation forms were sighted. This process is now embedded into everyday practice. A quality improvement sighted related to the use of a resident sign-in and sign-out book. This was put in place and staff and resident education was undertaken and minuted. A review occurred after two months and residents were using the book. On the day of audit one resident who went to the shops stated to the auditor that they had to sign out prior to going. As the residents are independently mobile and they come and go as they wish and this process identifies who is in the facility at

		any given time should an emergency occur. An initial resident satisfaction audit was completed in January 2018 to identify to the current owner that residents' needs were being met. No negative comments were made. A further resident and family satisfaction surveys was undertaken in July 2018 which showed that residents and family are happy with all the services provided. Both managers stated that if any concerns or issues were to be raised they would address them using the corrective action or quality improvement process. Resident satisfaction surveys will be conducted at least annually. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are provided by an off-site developer and personalised to the service. The policies and procedures are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Both managers described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The managers are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. There was a current risk register in place which included chemical hazards. The register identifies newly identified risks and hazards, how they are managed and the frequency of monitoring.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. One example relates to a resident who had an increased number of falls. The follow up included gaining the correct walking aid for the resident, educating the resident on correct use, and staff undertook close monitoring. No further falls have been recorded for the resident over a two month period. Adverse event data is collated, analysed and reported to the owner manager and at staff meetings. The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications (eg, public health) since the previous audit.
Standard 1.2.7: Human Resource Management Human resource	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		organisation's policies are being consistently implemented and records are maintained. The new owner manager has undertaken police vetting for all existing staff and will continue to do this for newly employed staff. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and then an annual staff appraisal. All staff appraisals were up to date. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The service maintains a record of individual staff education and training. Training and education records showed that guest speakers present on-site and staff are encouraged to attend off-site education related to the role they undertake. This includes attendance at ADHB study days. The nurse manager is trained and competent to complete interRAI assessments and maintains their annual competency requirements. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI. A registered nurse from a sister facility is also interRAI competent and covers the nurse manager when on leave should any interRAI assessments be required.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a six-week roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All clinical staff hold current first aid certificates. The nurse manager (RN) works four days a week at Turama House Rest Home and one day a week at a near-by sister facility for which she also undertakes on-call duties. The owner manager visits the facility at least once a day including weekends. There is a dedicated cook seven hours per day, seven days a week and a diversional therapist who undertakes activities five days a week. One dedicated staff member undertakes laundry and cleaning seven days a week.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
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	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. This was sighted in the six residents' files reviewed. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate documentation and communication of all parties involved. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using a paper-based system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are

with current legislative requirements and safe practice guidelines.		competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as requested and at two monthly intervals the pharmacist reconciles all residents' medication charts with the nurse manager. At the time of audit there were no residents requiring controlled drugs. The controlled drug register provided evidence of weekly stock checks up until the 19 July 2018; at that time a reconciliation of the controlled drug was completed by the pharmacist and the non-required medication was returned to the pharmacy. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used. There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
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	The food service is provided on site by one of two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. There were no recommendations made at that time. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries and expires 29 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with care staff completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Personal food and/or cultural food preferences, any special diets and modified texture requirements are made known to kitchen and care staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in

		an unhurried fashion and those requiring assistance had this provided.
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	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and a depression scale as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the one trained interRAI assessor on site who is the nurse manager/registered nurse. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected client centred support needs of residents of all ages, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is efficient. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was

their assessed needs and desired outcomes.		available, suited to the level of care provided and in accordance with the residents' needs.
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	The activities programme is provided by an activity co-ordinator who is a trained diversional therapist holding the national Certificate in Diversional Therapy. The residents are supported Monday to Friday 9.00 am to 5.00 pm. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents of all ages and include ongoing interaction and participation within the community and the support of cultural and spiritual beliefs. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Evaluations include multidisciplinary reviews of residents where family are also invited to attend. Two monthly reconciliation of medication charts also occur and are completed by the nurse manager and pharmacist (see criterion 1.3.12.1). Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for risk of falls, infections, wounds and interventions to support two residents returning from having had surgery/a procedure. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has two 'house doctors', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or nurse manager sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		services for older persons service. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals have undertaken safe chemical handling training. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness with an expiry date 15 June 2019 is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The owner/manager has replaced the flooring including updating the bathroom flooring with non-slip vinyl. Soft furnishings have been replaced to ensure infection control standards are met. There is a documented plan for continued upgrading of residents' bedrooms. The testing and tagging of electrical equipment (September 2018) and calibration of bio medical equipment (April 2018) was current as confirmed in documentation reviewed, interviews with management and observation of the environment. The environment was hazard free, residents were safe and independence was promoted. External areas were safely maintained and are appropriate to the resident groups and setting. There are multiply doors to access outdoor areas with seating and shaded areas which were used by many residents on the days of audit. Residents confirmed that any repairs or maintenance required, are appropriately actioned by management and that they were happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one bedroom which has full ensuite facilities. Appropriately secured and approved handrails are

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.		provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence
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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are two bedrooms which are large enough to have two occupants, but all bedrooms were being used as single occupancy at the time of audit. The nurse manager confirmed that should a bedroom be shared approval would be sought from the resident and/or family. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. Residents interviewed confirmed they are very happy with their bedrooms.
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 relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There are two spacious lounge areas with a separate dining area. All areas enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry	FA	Laundry is undertaken on site in a dedicated laundry. Dedicated staff undertake laundry and cleaning seven days a week. The staff member interviewed on the day of audit demonstrated a sound knowledge of the laundry processes, dirty/clean flow, handling of soiled linen and safe chemical handling. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Clinical staff and the laundry/cleaning staff have received appropriate safe chemical handling training. A daily

services appropriate to the setting in which the service is being provided.		checklist for all cleaning duties undertaken is signed off by the staff member and reviewed by the nurse manager. The facility looks and smells clean. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through observation and the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. Civil defence supplies are checked monthly by the nurse manager to ensure they remain in-date. The current fire evacuation plan was approved by the New Zealand Fire Service in June 2000. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 24 September 2018 with no follow up required. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas BBQ's were sighted and meet the requirements for the 36 residents. There is bottled water stored at the facility as well as a large outdoor water storage tank. Emergency lighting is regularly tested to meet the requirements of the building warrant of fitness. Call bells alert staff to residents requiring assistance. The nurse manager, residents and families reported staff respond promptly to call bells. The time to respond to call bells is asked about at each residents' meeting and no negative comments have been made. Staff undertake nightly checks of doors and windows and confirmed they have no concerns around the security of the facility.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Electric heating is provided throughout the facility with gas heating in the front lounge and dining area. There are wall mounted electric heaters in each resident's bedroom. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a 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	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the gerontology clinical nurse specialist as required. The infection control programme and manual are reviewed annually. The nurse manager/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the director, and tabled at the monthly full staff meeting and quality/risk committee meeting. This committee includes the director and nurse manager. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role at the facility since December 2017. She has undertaken regular training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
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	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2018 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
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	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the IPC coordinator and reported to the director and all other staff. Twenty-two (22) residents and nine staff in April of 2018 had the flu vaccine. The facility has had a total of nine infections since January 2018 through to and including September 2018. It is noted that the facility did not have any infections for the month of January and May 2018. One resident has been identified with four of those nine infections due to co-morbidities. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection, with specialist advice sought and recommendations implemented. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is not benchmarked.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. It identifies that the service aims to be restraint free. The restraint register and staff meeting minutes sighted identified that the service is restraint free and that no restraint has been used since the new owner has been in place. (December 2017). The restraint coordinator (nurse manager) presents restraint management education and challenging behaviour

actively minimised.		management for all new staff as part of the orientation process and ongoing, at least annually, as part of the in-service education programme. The restraint coordinator would provide support and oversight for enabler and restraint management in the facility should it be implemented. They have a very clear understanding of their role and responsibilities as restraint coordinator. Policy states that restraint is used as a last resort when all alternatives have been explored and that enablers shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining resident's independence and safety.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and	CI	In January 2018, it was identified that the residents’ medication files did not meet best medication practice and guidelines thus the risk of a medication error increased. Of the 18 medication charts reviewed not all charts had photo identification, allergy status had not been acknowledged, eight medication charts did not show evidence of a three-monthly GP review and one medication chart was identified to have a medication dosage discrepancy between the GP and the mental health services. A project was undertaken to reduce and minimise the risk of medication errors. The nurse manager met with the pharmacist and a discussion was had with the two supporting GP’s. As a result, the medication charts are now pharmacy generated. The pharmacist and nurse manager meet two monthly and all residents’ medication charts are reconciled to ensure all medication requirements are meet. This reconciliation process was initiated in April 2018. For the months of July and September the reconciliation process has identified that all requirements have been meet and no corrective actions were required.	The medicines management system is rated as continuous improvement following a project to improve medicines safety by supporting staff to reduce and minimise the risk of medication errors and ensure that the medication charts meet best practice and guidelines. The two most recent reconciliation processes identified that all requirements have been meet and no corrective actions were required.

guidelines.			

End of the report.