Sodhi Enterprises Limited - Coronation Lodge Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Sodhi Enterprises Limited
Premises audited:	Coronation Lodge Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 January 2019 End date: 21 January 2019

Proposed changes to current services (if any): The provisional audit was completed to assess the suitability and preparedness of the prospective new owner/director. The intended date of purchase will be as soon as approval is received from Healthcert. Handover of the facility is intended to be the 29 March 2019.

Total beds occupied across all premises included in the audit on the first day of the audit: 21

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

General overview of the audit

Coronation Lodge rest home provides rest home level care for up to 22 residents. On the day of the audit there were 21 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family member, general practitioner, staff, manager and prospective new owner/director.

One of the current owner's is an experienced aged care manager and qualified diversional therapist. The service has been privately owned and operated by owner/directors since 2006. They are supported by a part-time registered nurse and long-serving staff. Residents and family interviewed were complimentary of the service they receive.

The prospective owner/director reported there will be no change to current policies, systems and the environment. An employment consultant has been engaged to ensure a smooth staff transition to new employment contracts. The current manager will continue to provide support to the new owner/director during the three-week handover period.

There was one area for improvement around aspects of medicine management.

Consumer rights

Coronation Lodge provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents interviewed verified ongoing involvement with community.

Organisational management

The quality and risk management plan and quality and risk policies describe Coronation Lodge's quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. Adverse, unplanned and untoward events are documented by staff. There is an implemented health and safety programme. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme

that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

The registered nurse (RN) is responsible for each stage of service provision. The RN assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

Medication policies reflect current guidelines. Medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were very satisfied with the meals.

Safe and appropriate environment

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are sufficient numbers of showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. There is a civil defence kit and

evidence of supplies in the event of an emergency in line with civil defence guidelines. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of approved restraints and enabler. There was one resident with two restraints and one resident with an enabler. Staff receive regular education and training on restraint minimisation. Restraint use is discussed at staff meetings. Internal audits monitor safe restraint use and compliance of policy and procedures.

Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. The infection control coordinator has attended external education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	49	0	0	1	0	0
Criteria	0	100	0	0	1	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 Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and care staff interviewed (one registered nurse (RN), two caregivers and one activity coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme. Interview with the prospective owner confirmed support would be provided by the current owner during a three-week handover and by the wife of the prospective owner/director who will be employed as the full-time RN clinical nurse manager.
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	FA	There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. All five resident files reviewed contained signed

choices and give informed consent.		consents. Resuscitation status had been signed appropriately. Advance directives were available identifying the resident's wishes for end of life care, including hospitalization. Copies of enduring power of attorney (EPOA) were available in the residents' files where required. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. The two caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. The one relative and five residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. The five long-term resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.
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	The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.

Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The privacy officer (manager) leads the investigation of any concerns/complaints in consultation with the RN for clinical concerns/complaints. Concerns/complaints are discussed at the monthly staff meeting as sighted in the meeting minutes. Complaints forms are visible within the facility. There have been three written complaints and one verbal concern made since the last audit (three in 2017 and one in 2018). Appropriate action including investigation has been taken within the required timeframes. The complainant signs the complaint form acknowledging satisfied with the outcome. Residents and families interviewed are aware of the complaints process. A complaints register is maintained for written and verbal concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The manager/owner or registered nurse discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident meetings. Five residents and one family member interviewed reported that the residents' rights were being upheld by the service.
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	The residents' personal belongings are used to decorate their rooms. Two caregivers interviewed reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued

needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		and fostered within the service. The service has access to a cultural advisor from the DHB. The manager has attended a half study day at the DHB on engaging effectively with Maori and Te Reo. Staff have attended cultural safety in-service in 2018. There are policies and guidelines to assist staff in the delivery of culturally safe care for Maori. There were no residents who identified as Māori on the day of the audit.
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	The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in consultation with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and the relative interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. A chaplain visits the residents (as they wish) on a weekly basis.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions and staff sign a code of conduct on employment. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Twenty-one staff attended code of conduct/professional boundaries in-service January 2019.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Good practice was evident. A registered nurse is available 15 hours a week and on-call for clinical concerns. There is an aged care nurse practitioner from the DHB who visits the facility regularly providing support and advice as required. Resident/family meetings are held bi-monthly facilitated by the manager wo is also a qualified diversional therapist. Residents and the relative interviewed reported that they are very satisfied with the services received. A resident/family satisfaction

		survey is completed annually, and confirmed residents/relatives are very satisfied with the services received.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Nine incident forms reviewed for January to date identified family were notified following a resident incident. The manager and RN confirm family are kept informed. The relative interviewed confirmed they are notified promptly of any incidents/accidents. Families receive regular newsletters.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Coronation Lodge provides care for up to 22 rest home level residents. There were 21 permanent residents on the day of audit. All residents were under the ARCC. The 2018 business plan has been reviewed and a 2019 business plan has been developed that includes the service philosophy of care, quality goals, timeframes and responsibility. The facility has been privately owned and operated for 8 years by company directors. The manager/owner is a qualified diversional therapist, and is non-clinical and supported by a part-time RN, administrator and long-serving staff. The manager has completed eight hours of professional development in the last year including advance care planning, Tasmania dementia course and attending at DHB forums. The manager is a career force assessor. The prospective owner/director acknowledge they have no experience managing a rest home level facility. He has completed a chartered accountant course and has management experience. His role will be overseeing the daily operations of the facility including payroll, human resources and business management. The prospective owner/director's wife is a RN currently practicing as a clinical nurse specialist and previously as an RN in rehabilitation in older people's health service and will become the clinical manager. The prospective owner/director has developed a business transition plan in that will allow for a seamless transition for residents and staff.

		He has engaged business consultant to advise on operational and financial matters. The existing philosophy of care will be adopted by the prospective owner/director. The current owner will provide support and mentor the new owner/director for a handover period of three weeks. The prospective owner/director has met with relevant DHB personnel and relevant authorities have been notified of pending change of ownership. The transition plan identifies appropriate management education including health and safety as soon as practical for the owner/director and interRAI training for the clinical manager soon after employment.
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	Interview with the prospective owner/director and current management, informed that there will be a handover period. The current manager and RN share the on-call requirement. The service also engages the services of an RN (working as a practice nurse) to provide clinical cover for the RN during periods of leave. The prospective owner/director and clinical manager will be available to the staff 24 hours and live within 10 minutes of the facility. A third family member is to be employed as a caregiver and also available 24 hours as required to cover for staff and provide additional assistance if required. Formal arrangements will be made to provide management and clinical cover for annual leave, however there is no leave planned within the first year of ownership.
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 quality and risk management plan and quality and risk policies describe Coronation Lodge's quality improvement processes. The service contracts an aged care consultant who maintains and reviews policies to ensure they align with current good practice and meet legislative requirements. Policy updates are received, and staff are required to read and sign. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data (for example skin tears, bruising, falls,

		pressure injuries). Corrective actions are documented, implemented where improvements are identified and are regularly evaluated. Information including identifying trends, analysis and graphs are shared with all staff as confirmed in meeting minutes and during interviews. A risk management plan is in place. The manager has attended health and safety education for health and safety trainees. Staff receive health and safety training on orientation to the service and annually as part of the compulsory education day. Staff complete health and safety competencies. The community physio provides training on safe manual handling and transfers. Health and safety are discussed at the monthly staff meetings. Staff report hazards on report forms and a hazard board is maintained. Actual and potential risks are documented on the current hazard register. Falls management strategies and the development of specific falls management plans are in place to meet the needs of individual resident who are at risk of falling. There is an internal audit programme that covers environmental and clinical areas. Corrective actions have been generated and completed for any audit outcomes less than 100% and there was evidence of re-audits as part of the corrective action plan. Annual resident/relative satisfaction survey was last completed in February 2018. All residents and families were very satisfied with the care and services provided. Results for the surveys fed back to participants and the staff through meetings. Interview with the prospective owner confirmed the current quality management system and performance monitoring programme will continue following the sale. The manager will remain for three weeks to mentor the new owner to the quality risk system. There will be no changes to policies and the prospective owner will continue to engage the aged care consultant for the review and update of polices.
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	FA	There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Nine accident/incident forms

manner.		were reviewed (eight falls and one missing person). There was timely RN assessment and follow-up including relative notifications, corrective action and GP review as required. Neurologic observations were conducted for suspected head injuries. The manager and RN reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. One section 31 notification form was completed (January 2019) for police investigation in the missing resident incident.
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.	FA	There are human resources policies to support recruitment practices. Five staff files sampled (one registered nurse, one care-coordinator, one caregiver, one activity coordinator and one cook) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the RN, manager (DT) and allied health professionals. All staff have a current first aid certificate. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training program covering all the relevant requirements is implemented and attendance records are maintained. There is an in-service topic each month in conjunction with the staff meeting. The manager and RN have initiated a study day that covers all compulsory training. The study day is run twice yearly to ensure all staff have the opportunity to attend. Clinical staff complete competencies relevant to their role including medication competencies, clinical skills, restraint and challenging behaviour. The manager is a career force assessor and currently has two students progressing through the career force units.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and

suitably qualified/skilled and/or experienced service providers.		support. The manager is full-time and on call for non-clinical matters. The RN works 15 hours a week over three days and is available on-call for clinical matters. There is an administrator from Monday to Friday 9am to midday. On the morning shift there is a care coordinator (senior caregiver) from 7am to 3pm. There are two caregivers, one from 7am to 1pm and a second who is on duty 7am to 10am (for assisting with showers). There are two caregivers on afternoon shift (one full shift and one finishing at 9pm). There is one caregiver on night shift with an on-call manager or RN. The activity coordinator is on duty from 9am to noon Monday to Friday and is supported by the manager/DT as required. There is a cook on duty from 7am to 2.30pm and an afternoon kitchenhand from 4pm to 7.30pm. Laundry is completed by the shower caregiver from 10.15 to 1.30pm daily. Housekeeping is completed by a designated staff member from 9am to 1.30pm. There is a part-time maintenance person. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times. Annual leave and sickness are covered. The prospective owner has engaged an employment/human resources consultant to assist with the restructure of care hours and transition of staff onto a new employment contract the date of settlement. The RN (wife of the new owner/director) will be employed full-time as the clinical manager. This is documented in the transition plan.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Archived records are kept

		secure. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or RN, 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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has information they offer residents on admission. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Five admission agreements sighted were signed and dated.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow transfer envelope' accompanies residents to receiving facilities and communication with family is made.
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.	PA Moderate	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering an inhaler on the day of audit. The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication competent caregivers administer medications. Staff have up-to-date medication competencies completed and there has been medication education in the last year. The medication fridge temperature is checked daily. Medication practice did not always align with policy and guidelines. Staff sign for the administration of medications on medication signing sheets. Ten medication charts reviewed met legislative requirements. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.

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 service has two cooks, who work a rolling roster with one being on each day. Both have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from the kitchen to the dining room. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. The four-weekly summer/winter menu is approved by a dietitian. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen and staff were converse with the likes/ dislikes of each resident. Special equipment such as lipped plates are available. These were recorded in the kitchen Audits are implemented to monitor performance. The food control plan has been registered. It is awaiting verification. Kitchen fridge and freezer temperatures were monitored and recorded daily. The cooks prepare the evening meal and leave this for the afternoon kitchenhand to heat and serve. Feedback on meals is received directly, through meeting minutes and surveys. All residents and the family member interviewed were very satisfied with the meals.
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 potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency and/or given suggestions of facilities offering appropriate services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are	FA	Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed

gathered and recorded in a timely manner.		for all long-term residents' files reviewed. Goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) falls risk, pressure injury risk, pain and continence.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status and sighted for infections, pain, mouth condition and skin care. "Emergency Plans" were in use for residents with high risk of choking and hypoglycaemia. Residents and the relative interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist (now changed to the RN foot specialist), speech therapist, hospice, social worker, psychogeriatrician and mental health care team for older people.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs change. Residents' falls are reported on incident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified. Care staff interviewed, stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies. There were no wounds being treated. Upon review of documentation when there had been wounds, wound assessment, wound management and evaluation forms were in place and wound monitoring occurred as planned. There were no pressure injuries.

		Monitoring forms are in use as applicable such as weight, vital signs and fluid intake. There was evidence of behaviour charts being used for any residents that exhibit challenging behaviours.
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 one activity coordinator (who was previously a carer) who works 15 hours a week minimum. The manager is a qualified diversional therapist and plans and oversees the activities programme. The activity coordinator attends all in-service and has a first aid certificate. On the day of audit, residents were observed participating in an active programme including newspaper reading, doing exercises, and playing housie. There is a weekly programme in large print on noticeboards. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music, entertainment, outings and walks outside. There were specific outings (weekly and monthly) for the younger resident (under the ARCC). Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is a church service fortnightly and a minister is available at any time. There are van outings three times a week and residents are taken to Age Concern fortnightly. A guest speaker comes to the home monthly and entertainers twice a month. Special events are celebrated. The facility has one cat and a resident has their own cat. There is community input from day care children and school children. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family (The DT/manager undertakes this). Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly, at the same time as the review of the long-term care plan. Resident meetings are held 2 monthly. Residents interviewed spoke positively about the activity programme.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The four long-term care plans reviewed (one of the five reviewed was a new admission) had been evaluated against the resident goals as met or unmet, by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activity plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP if available and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan and documented communication with next of kin evidenced this was occurring.
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	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the speech therapist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
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	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.
Standard 1.4.2: Facility Specifications	FA	The building holds a current warrant of fitness which expires 29 March 2019. There is a maintenance person on site who works 20 hours per

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		week. Contractors are used when required. All medical and electrical equipment has undergone annual safety testing. Stand on weigh scales are used. Hot water temperatures have been monitored in resident areas and were within the acceptable range. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well-maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Caregivers stated they had sufficient equipment to safely deliver cares as outlined in the resident care plans. The prospective new owner/director confirmed on interview there are no changes to the environment planned within the first year of ownership.
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	All resident rooms have hand basins. There are sufficient communal toilets and showers. Fixtures, fittings and flooring are appropriate for this setting. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if appropriate. There are privacy signs on all shower/toilet doors and locks that may be opened from the outside if necessary.
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	There is one large bedroom certified as a double and is currently being shared by a couple (the wife was in hospital on the day of audit). There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed, reported that they have more than adequate space to provide care to residents. All rooms were in good condition, light and bright, freshly painted, well personalised and with a high standard of furniture, including a large number of electric beds and all with pressure redistributing mattresses.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	There is a large lounge which is also used for activities and opens to an attractive, easily accessible outdoor area. There is a spacious dining

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		room. Both are easily viewed from the care station.
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	All laundry is done on site. The laundry is operated by the caregivers. The laundry is divided into a 'dirty' and 'clean' area. There are laundry and cleaning procedures available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away when not in use. All chemical containers are labelled correctly. There is one sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept locked when not in use. There is personal protective equipment readily available.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency, disaster policies and procedures are documented for the service. The orientation programme and annual education/training programme include fire, emergency management and security training. Staff interviewed confirmed their understanding of emergency procedures. There is an approved fire evacuation plan. Fire drills occur every six months (last fire drill occurred October 2018). A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water (1800 litre tank), and civil defence supplies which are checked annually. The kitchen has gas and electric cooking and there is a gas BBQ and portable hangi available for alternate cooking. There is two-hour battery backup for emergency lighting. The facility is secure at night. A call bell system is in place including all resident rooms, dining room, communal toilets/showers. There is a hand bell available in the lounge adjacent to the dining room and nurses' station There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All bedrooms and communal areas have ample natural light and

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		ventilation. All heating in bedrooms is electrical and gas in communal areas. Staff and residents interviewed stated that this is effective. There is a designated smoking shelter in the grounds where residents may smoke. All other areas are smoke free.
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 RN has responsibility for infection control and has been in the role for eight years. Responsibility for infection control is described in the job description. The infection control coordinator oversees infection control and collates events for the facility. The administrator assists with the data input and graphs that are discussed at the staff meetings. The infection control programme is reviewed annually in February each year in consultation with the manager and staff. Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed at the entrance to the facility and throughout the facility. Residents are offered the influenza vaccine. There have been no outbreaks.
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 infection control coordinator has attended a residential study day at the DHB in August 2018 which included infection control and prevention education. There is access to infection control expertise within the DHB, aged care consultant, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.
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	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant and reviewed January 2019. The infection control manual is readily available to staff.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the compulsory annual training day. Staff complete infection control competencies. In-service's for 2018 also included food safety, wound care and continence management. Resident education is expected to occur as part of providing daily cares.
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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly staff meeting and includes discussion around trends and analysis of infections and corrective actions as required. The service completes monthly and annual comparisons of infection rates for types of infections. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. During the audit, there was one resident with two restraints (bedrail and lap belt) and one resident using an enabler (bedrail). Verbal consent for enabler use had been witnessed and signed by the EPOA which has been activated. There is a restraint coordinator for the service, who is the manager/diversional therapist. The service has been DHB approved for the use of keypad entry and exit at the main entrance due to the proximity of a main road and to maintain safety for individual residents as assessed. The code is available to residents and staff. There is only one resident requiring environmental door restraint who is currently being assessed by the restraint coordinator on the day of audit.

Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The manager is the restraint coordinator. Assessment and approval process for restraint use includes the restraint approval group of the manager, RN and care coordinator. The use of restraint is documented in the resident care plan including frequency of monitoring. Restraint minimisation, enabler use and challenging behaviour training is included in the training programme. Care staff complete restraint competencies. Restraint use is discussed at staff meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whanau, in the file reviewed. The restraint coordinator, the resident and/or their representative and a GP were involved in the assessment and consent process.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified through the assessment and approval processes. The file reviewed had completed assessment forms and care plans that reflected risk. Monitoring forms reviewed evidence that monitoring was occurring in the prescribed timeframes. The service has a restraint and enablers register which was up to date
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Evaluation timeframes are determined by policy and risk levels. The service has documented evaluation of restraint every six months in conjunction with the six-monthly care plan evaluation. The RN reviews restraint weekly for the one resident as written in the progress notes. The GP reviews restraint use for the resident at the three-monthly GP review. Restraint practice is reviewed every month by the restraint coordinator during discussion with the staff and RN at monthly meetings.

Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Organisational review of restraint use was evidenced to be conducted annually by the approval group. A review of all enabler and restraint use occurs monthly at the staff meeting as evidenced in the meeting minutes. Internal audits are completed as part of the quality monitoring programme.

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 1.3.12.1 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 guidelines.	PA Moderate	Medications were prepacked by the pharmacy for all tablets including as required medications if required, and if there were respite residents. Liquid medications were dispensed for the individual resident by the pharmacy. These medications were checked by the RN when arriving on site. Caregivers who had demonstrated competency in administering medications were responsible for administering medications. A register of these staff members is maintained, and ongoing education is provided. Medication practice did not always align with policy and guidelines.	(i)It was noted that the requirement for eye drops to be dated once opened was not occurring. Three of three eyedrops in use had not been dated on opening and (ii) Three liquid medications were observed to be poured into receptacles prior to the commencement of the medication administration round. The medication pottles were not labelled (resident or content) and left on the top of the medication trolley until administered to three different residents.	(i)Ensure all eyedrops are dated on opening and (ii) ensure medicine administration practice complies with medication policy and procedure. 30 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.