

ERH Care Limited - Elizabeth 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:	ERH Care Limited
Premises audited:	Elizabeth Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 March 2019 End date: 6 March 2019
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:	9

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. Elizabeth Retirement Home is owned and operated by a group of owners who oversee another aged care facility and accommodation businesses. The director (non-clinical) is actively involved in the business management of the service. The facility manager is a qualified registered nurse and is responsible for the operation and clinical management of the facility. The service provides rest home level care and independent boarder accommodation for up to 26 residents. On the day of the audit there were nine rest home residents.

The residents and relative spoke positively about the care provided at Elizabeth House.

This provisional audit was undertaken to establish the level of preparedness of the prospective owner to provide a health and disability service and to assess the level of conformity of the current provider prior to the purchase. This certification audit was conducted against the Health and Disability Service Standards and the organisations contract with the district health board (DHB). The audit process included the review of policies and procedures; sampling of resident and staff files; observations; interviews with residents, a resident's family member, management, staff, and a general practitioner.

The prospective provider is a current director of the current ownership company. There are no planned changes to management, policies, procedures, staffing or implemented processes.

This audit identified the following areas for the improvement: documentation of designation, service provider identification, delivery timeframes, care planning, documentation, kitchen environment, maintenance, cleaning and infection control coordinator training.

Consumer rights Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Māori values and beliefs are understood and respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community.

Complaints processes are managed appropriately.

Organisational management

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The facility manager is a registered nurse (RN) and is supported by a second RN. The facility manager is on call when not available on site.

There are adequate numbers of staff on duty to ensure residents are safe.

Continuum of service delivery

There is an admission package available prior to, or on entry to the service. The facility manager is responsible for service provision. A part time registered nurse assists with interRAI assessments and relieving. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

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

The activities 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. Residents and families report satisfaction with the activities programme.

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

Safe and appropriate environment

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. A selection of residents' rooms have ensuites and there are sufficient communal showers/toilets for the others. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are constructed for ease of resident access and ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to

emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. No restraint or enabler was in use.

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. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	38	0	5	2	0	0
Criteria	0	85	0	6	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policy relating to the Code is implemented. The facility manager/registered nurse (RN), prospective owner and six staff interviewed (one RN, two caregivers, one activities coordinator, one cook, one cleaner/laundry) could describe how the Code is incorporated into their role and responsibilities. Staff receive training about the Code during their induction to the service. This continues through the staff education and training programme.
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	There are established policies and procedures around informed consent and advanced directives. There are signed consents for release of information, outings and photographs in five resident files sampled. Resuscitation status and advance directives on all files sampled were appropriately signed. Discussions with the facility manager, and two caregivers confirmed that they were familiar with the requirements to

		obtain informed consent for personal cares. Discussions with residents confirmed that staff seek permission prior to providing cares.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Health and Disability Commissioner (HDC) advocacy details 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 if required. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, which was evidenced through interviews and observations.</p> <p>Community links are established with examples provided.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A policy addressing the complaints process meets requirements set forth by the Health and Disability Commissioner (HDC). The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms were sighted in a visible location.</p> <p>A complaints register is maintained. No complaints were lodged for 2017 or 2019 (year-to-date). One complaint was lodged through the DHB in 2018. A full investigation took place and corrective actions have been implemented around medication management.</p> <p>Discussions with residents and families confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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 facility manager/RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during three-monthly residents' meetings. All six residents and one family interviewed could provide examples of ways that the rights of residents were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that 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. Toilets and showers have appropriate signage and door locks in place.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. This begins during their induction to the service.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Māori health policy is documented for the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.</p> <p>There was one resident living at the facility who identified as Māori. A detailed Māori assessment had been completed that covered the care required for spiritual, mental, physical and emotional well-being. The resident's iwi, food preferences and special instructions around death and dying were documented.</p> <p>Education on cultural awareness begins during the new employee's</p>

		induction to the service and continues as a regular education topic. The code is posted in both English and Māori. Also posted is tikanga best practice.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all five care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are described in job descriptions. Boundaries are also discussed with each new employee during their induction to the service. 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, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The facility manager/RN is supported by a second RN who is available on a part-time basis and assists with interRAI assessments. The facility manager is available on call if not available on site. The general practitioner (GP) visits fortnightly and residents are reviewed by the GP every three months at a minimum.</p> <p>Resident meetings are held three-monthly. Residents and family/whānau interviewed reported that they are satisfied with the services received. A resident/family satisfaction survey completed in 2018 confirmed that residents are either satisfied or very satisfied with the services that they receive.</p>

		<p>The service receives support from the district health board (DHB). The environment allows for close relationships between the staff and residents. An activities coordinator is onsite five days a week. Caregivers assist with activities in the absence of the activities coordinator.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy sighted is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. This is an improvement from the previous audit. The care staff interviewed understood about open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. Families and staff are utilised in the first instance. There were no residents at the facility who were unable to speak or understand English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Elizabeth Retirement Village provides rest home level care for up to 26 residents. On the day of the audit there were nine residents on the ARC contract. There were also nine boarders living at the facility.</p> <p>A philosophy, mission, vision and values are in place. The 2019 strategic, quality and risk management plan is up to date and is regularly reviewed by the owners, director and facility manager/RN. The owners and director oversee multiple facilities including this aged care facility, a 24-bed dementia facility and motels. The director holds experience in marketing and accounting. He has worked with the owners as a director since 2016. Annual practising certificates were sighted for registered health professionals (RNs, GPs, pharmacy, podiatry). The facility manager/RN has maintained a minimum of eight hours of professional development relating to the management of an aged care facility. She is currently taking a first line management</p>

		<p>course through the DHB that began in June 2018. These are all improvements from the previous audit.</p> <p>The prospective owner has been the director of this facility for the past three years. He is planning to purchase this facility from the current owners. The prospective owner reported that HealthCERT and the DHB have been notified regarding the purchase. He reported that the handover is tentatively scheduled for early April. He does not plan to make any changes to the facility and will continue to operate using the current 2019 strategic, quality and risk management plan (that he was responsible for developing with assistance from the facility manager/RN). The director and the facility manager/RN will continue to receive assistance from a quality consultant who has worked in the aged care sector for 19 years and has been providing 10 hours of consulting per week.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The RN, who completes the interRAI assessments for the facility, is available to provide RN cover when the facility manager/RN is not available. This individual previously was the clinical manager for this facility. This is an improvement from the previous audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management system is understood and being implemented, as confirmed during interviews with the facility manager/RN and staff. This is an improvement from the previous audit.</p> <p>Policies and procedures align with current good practice and meet legislative requirements. These policies were developed by an external consultant but were not available for sighting at the previous audit. Policies have been reviewed, modified (where appropriate) and implemented. They are reviewed annually as per the document review face sheet in the front of each policy and procedures manual. New policies and policy amendments are discussed with staff as evidenced in staff meeting minutes. These are all improvements from the previous audit. The prospective owner interviewed, reported that the plans to use the same policies and procedures as the ones that are currently in place.</p>

		<p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints received (if any). Data is collected for a range of adverse event data (eg, skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Where improvements are identified, corrective actions are documented. Quality data, outcomes and corrective actions are discussed with staff in the monthly staff meetings. These are improvement from the previous audit. The prospective owner interviewed reported that he plans to continue with the current quality management plan.</p> <p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Staff health and safety training begins during their induction to the service. Health and safety meetings follow the monthly staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. Contractors are inducted into the facility's health and safety programme. These are improvements from the previous audit. During the audit, there was a large volume of water on the floor in the laundry that was a risk, but no wet floor signage was in place to alert staff (link 1.4.6.3).</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) decluttering residents' rooms, and intentional rounding.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Ten accident/incident forms were reviewed. Each event involving a clinical adverse event reflected a clinical assessment and follow up by the facility manager/RN. Neurologic observations are conducted for suspected head injuries.</p> <p>All chemicals sighted were stored in secure areas, out of the reach of residents. Staff have access to accident/incident forms. These are</p>

		<p>improvements from the previous audit.</p> <p>The facility manager/RN is aware of statutory responsibilities in regard to essential notification. One section 31 report has been required since the previous audit for a missing resident.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (three caregivers, one RN, one cleaner/laundry) included evidence of the recruitment process including reference checking, signed employment contracts and job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that they believed new staff were adequately orientated to the service. Professional qualifications and practising certificates (where applicable) are validated. These are improvements from the previous audit.</p> <p>An education and training programme is provided for staff that meets contractual obligations. In-service's are offered monthly (at a minimum) with attendance records sighted. In addition, staff attend the DHB study days for nursing staff and caregivers. Competencies are completed, specific to worker type. These are improvements from the previous audit.</p> <p>Both RNs have completed their interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy aligns with contractual requirements. This is an improvement from the previous audit.</p> <p>The director/prospective owner reported that he is onsite approximately 20 hours per week. The facility manager/RN works full-time (Monday – Friday) and is on call when not available onsite. A second RN is rostered for 10 hours per week to assist with the completion of interRAI assessments. This individual also covers in the absence of the facility manager.</p> <p>There are adequate numbers of caregivers rostered to care for the nine residents. One caregiver is rostered on each shift. A second caregiver</p>

		<p>is rostered during the night shift (sleeps over). In addition, an activities coordinator is rostered five days a week (0900 – 1300). Staffing is flexible to meet the acuity and needs of the residents.</p> <p>Separate cleaning/laundry staff are employed six days a week (0900 – 1300). Interviews with residents and families confirmed staffing overall was satisfactory. The facility manager/RN confirmed that the (nine) boarders do not require assistance by the caregivers.</p> <p>The prospective owner interviewed stated that he does not plan to change the staffing roster.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.</p> <p>Residents' files were held in two separate files and were lacking service integration (link 1.3.5.3). Entries were legible, dated, timed and signed by the relevant caregiver or RN, but designation of the caregiver was frequently missing in the progress notes.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy.</p> <p>The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the Age Related Residential Contract (ARCC). Exclusions from the service are included in the admission agreement. All five admission agreements viewed were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer</p>

		form accompanies residents to receiving facilities and communication with family is made.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There were no standing orders.</p> <p>The facility uses a sealed pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses and medication competent care staff administer medications. Medication competencies are updated annually, and staff attend annual education. The medication is securely stored in a locked cupboard and in a sealed container in the kitchen fridge. The fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on an electronic administration signing system. All nine resident medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The service employs two cooks who between them, cover all shifts. A registered food control plan has been implemented and verified until 27 June 2019. The cooks have current food safety certificates. The main 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 residents in the dining rooms. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded weekly. Food temperatures are checked at all meals. These are all within safe limits. There are completed cleaning</p>

		<p>schedules, however on the day of audit there was evidence of flying insects in the area throughout the day.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is written and approved by an external dietitian. This is an improvement from the previous audit. All residents interviewed were happy with the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occurs and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files contain appropriate assessment tools and assessments that have been reviewed at least six-monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. Care plans sampled have been developed on the basis of these assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans are individually developed with the resident, and family involvement is included where appropriate. The RN is responsible for all aspects of care planning. Not all care plans included specific interventions for all identified care needs. The family/whānau member interviewed were satisfied with the care provided. Assessments and care plans included input from allied health including the GPs, nurse specialist, and podiatry. Physiotherapy is available if needed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All five long-term care plans sampled have interventions documented. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>There were no wounds on the day of audit. The facility manager/RN advised wound care is undertaken by the RN or caregivers who report to the RN if there are any issues identified. A review of the previous wound documentation for one resident identified wounds are assessed and managed appropriately. The facility has access to wound care specialist advice if required.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p> <p>Records of care plans were all available to view. The previous partial attainment has been addressed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a weekly programme and a qualified diversional therapist who works ten hours per week. She is supported by an activities coordinator who provides an activities programme for five hours a day, Monday to Friday. The programme is distributed to residents each week and care and activities staff remind residents of the days programme, individually each day. Residents have the choice of a variety of activities in which to participate. These include exercises; discussion groups, morning news, bingo; crafts; games; and quizzes.</p> <p>Those residents who prefer to stay in their room have one-on-one visits</p>

		<p>to check if there is anything they need and to have a chat.</p> <p>There are weekly church services and the denominations rotate.</p> <p>There are fortnightly van outings. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly and provide an opportunity for residents to provide feedback.</p> <p>Activity assessments, care plans and evaluations were sighted for all resident files reviewed. The previous shortfall has been addressed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The five long-term care plans reviewed have been reviewed by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each resident and these have been evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. The residents interviewed confirmed that they are involved in care plan reviews. The previous shortfall has been addressed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the physiotherapist and Mental Health Services for Older People. Discussion with the registered nurse confirmed that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person described the safe management of hazardous material.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>The building holds a current warrant of fitness (30th September 2019). There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. All hoists and scales have been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and are within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted. Ensuites, communal showers and toilets have nonslip vinyl flooring. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained with outdoor areas with seating and shade. There is safe access to all communal areas.</p> <p>The prospective owner confirmed on interview there are no environmental changes planned in the short term, apart from ongoing maintenance and upgrades to furnishings and equipment as needed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>All rooms are single occupancy. All bedrooms have hand basins. There are adequate numbers of communal toilets and showers for residents. There is appropriate signage, easy clean flooring and</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		fixtures and handrails appropriately placed. Residents confirmed their privacy is maintained at all times. There is ample space in all communal toilet and shower areas to accommodate shower chairs if appropriate. There are privacy signs on all shower/toilet doors.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	Twenty rooms (all single occupancy) have individual toilets and hand basins. Six rooms have toilets only. The rooms are spacious enough for the resident to easily manoeuvre around with mobility aids as required. Residents are encouraged to personalise their rooms as desired.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. Some lounges open out onto attractive courtyard areas. There are spacious dining rooms in each wing.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	All laundry is undertaken onsite in a dedicated laundry by staff. Commercial equipment and resources are available. Resident's personal items are laundered onsite or by family members if requested. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or safely stored when not in use, as sighted on the day of the audit. Cleaning is done by onsite cleaners.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months. The orientation programme and education and training schedule include fire training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required

		<p>timeframes.</p> <p>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, and blankets. A gas cooker is available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.</p> <p>One staff is available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. Electric heating is provided with radiators in all rooms and bathrooms. The communal areas were warm and well ventilated throughout the audit. Residents and the family member interviewed confirmed that the facility is maintained at a comfortable temperature. The facility has a small outside smoking area by the garden shed.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is the facility manager/RN who has been in the role for one year. The infection control coordinator (ICC) oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and review of the education programme. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. The previous partial attainment has been addressed.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are</p>

		appropriately placed throughout the facility.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The facility manager/RN is the infection prevention and control coordinator. Infection control trends are discussed at the management and monthly staff meetings, or as when necessary. The infection control coordinator has access to the GP, local laboratory, the infection control nurse specialist at the DHB and public health departments at the local DHB for advice.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Elizabeth Retirement Home has documented policies and procedures in place, reflective of current best practise and legislative requirements. Guidelines include defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly (last February 2017) by the infection control coordinator. The ICC is responsible for monitoring and implementing the infection control programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	PA Low	<p>The infection control coordinator (ICC) is responsible for coordinating/providing education and training to staff; however, the infection control coordinator has not had recent training. Training on infection control for all staff is included in orientation and as part of the annual training schedule. Hand washing competencies are completed on orientation and are ongoing.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports, and</p>

infection control programme.		<p>short-term care plans are completed for all infections. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data and relevant information is shared with staff at regular meetings. Trends are identified, and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. The previous partial attainment has been addressed.</p> <p>There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks of infection since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. No residents were using restraints or enablers. The facility manager/RN is the designated restraint coordinator. She is knowledgeable regarding this role. Staff receive training on restraint minimisation. This begins during their orientation and continues annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Progress notes in five residents' files reviewed failed to consistently reflect the caregiver's designation.	Progress notes that were signed by caregivers were frequently missing their designation.	Ensure that caregivers always place their designation after their signature. 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Kitchen cleaning was completed as scheduled, however throughout the day there was evidence there were flying insects and there were no insect mesh screens on open windows. Cleaning schedules are completed as required.	On the day of audit, a number of flying insects were sighted in the kitchen. There were no insect screens installed on kitchen windows.	Install insect screens over opening kitchen windows 90 days
Criterion 1.3.3.3	PA Low	Registered nurses' complete initial	i) Two of five six monthly interRAI	i) Ensure interRAI

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		assessments and care plans within 24 hours of admission. Long-term care plans were completed within 21 days of admission. InterRAI assessments have been reviewed six monthly for two of five residents. Two residents do not require the interRAI assessment completed. The facility manager/RN documents in the resident's progress notes but not always in expected timeframes.	assessments had not been completed within required timeframes. ii) Registered nurse reviews were not evident in progress notes in some files for three weeks or more.	assessments are completed six monthly or sooner if required. ii) Ensure the registered nurse documents regular reviews in progress notes. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	The resident file includes medical notes, EPOA documentation, assessments, care plans, historic progress notes and consents. Activities attendance information is stored separately. Progress notes and monitoring charts are stored in another file. Incident forms relating to the resident are stored in an adverse event folder. Admission agreements are stored upstairs.	Current progress notes, monitoring charts and incidents forms were not stored in the residents file	Ensure resident files are integrated 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Long-term care plans were documented by the registered nurse. All residents had a long-term care plan in place. Caregivers were knowledgeable about the individual resident care needs. The care plans documented the resident health conditions, but not all files included sufficient interventions to guide care staff.	(i) One resident file did not reflect the risk and interventions needed, associated with diminished sight and hearing and nutritional requirements. (ii) One resident with insulin dependent diabetes did not include reportable ranges, hypo and hyperglycaemic management.	(i)-(ii) Ensure that care plans have interventions and care documented for all resident needs. 60 days
Criterion 1.4.2.4	PA	A maintenance book provides a record of	i) A toilet in a resident room had	Ensure all repairs

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	Moderate	required maintenance; however, this does not evidence that required repairs and maintenance are completed in a timely manner.	<p>been flushing continuously for several weeks.</p> <p>ii) Lightbulbs in residents' rooms and communal areas were not evidenced as being replaced as required and on the day of audit, a resident with diminished sight confirmed his light bulb had not worked for four days.</p> <p>iii) A leaking washing machine (in an area accessed by boarders) had been logged as requiring repair for four days.</p>	<p>are carried out as required in a timely manner.</p> <p>60 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	The cleaner is responsible for replacing cleaning supplies as required, however this is not always implemented.	On the day of audit, it was noted paper towels and soap dispensers in some areas remained empty.	<p>Ensure paper products and liquid soap is replenished as required.</p> <p>90 days</p>
<p>Criterion 3.4.1</p> <p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.</p>	PA Low	The infection control coordinator (ICC) has been in the position for one year and has not attended training to update her knowledge of current infection control practises.	The ICC has not received training updates relevant to her position.	<p>Ensure the ICC attends infection control training.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.