

Agape Care Limited - Milton Court Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Agape Care Limited
Premises audited:	Milton Court Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 15 April 2019 End date: 16 April 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:	33

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Milton Court Rest Home is privately owned and operated. The rest home provides rest home and dementia level of care for up to 36 residents. On the day of the audit there were 33 residents.

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

The owner/manager (registered nurse) is on site during the week with another registered nurse providing clinical oversight. The residents and relatives spoke positively about the care and supports provided at Milton Court Rest Home.

Improvements identified at the audit are required to the following: review of policies; and environment shortfalls.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed at reception with pamphlets given to residents and family on entry. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

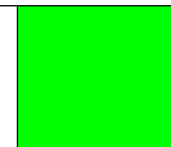
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Milton Court Rest Home is implementing a quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards.

Human resources policies are in place, including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are staff on duty at all times to meet needs of residents in both the rest home and dementia unit. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. The annual training plan is implemented.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

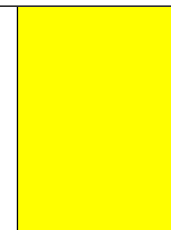
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the general practitioner.

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

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Some standards applicable to this service partially attained and of low risk.

Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies in the event of an emergency. There is a staff member on duty at all times who has completed first aid training. A call bell system is operational and responded to in a timely manner.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There is one ensuite and fifteen rooms with toilets. All other rooms share communal 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. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service maintains a restraint-free environment. There are policies and procedures to follow if restraint or enablers are required. There were no residents using restraints or enablers during the audit and the service has maintained a restraint free environment for seven years.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. 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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	<p>The service has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code) (link 1.2.3.3). Staff interviewed (two healthcare assistants who work across all shifts and both areas, the registered nurse, owner/manager, cook, activities coordinator, maintenance, laundry and cleaning staff) can describe how they incorporate resident choice into their activities of daily living.</p> <p>Seven residents (rest home) and four relatives (one rest home and three with family in the dementia level of care) interviewed, confirmed that information has been provided around the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). They all stated that their rights are respected when receiving resident related services and care. Residents and family confirmed that they received information around the Code on entry to the service.</p>
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (three rest home and three dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is</p>

informed choices and give informed consent.		filed in the residents' charts. In the dementia unit all residents sampled had activated EPOAs.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents and families are provided with a copy of The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) and advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the facility entrance. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receives education and training on the role of advocacy services. Care staff interviewed were aware of the resident's right to advocacy services and how to access the information.
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 has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. Rest home residents interviewed confirmed that family and friends can visit at any time and visitors were observed attending the dementia unit on the days of audit. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme. Activity and care staff take residents from the rest home and dementia unit out walking in the community in the morning and afternoon.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the manager using a complaints' register. There have been no complaints for 2018 or 2019 since the previous audit. There have been two complaints to date and these were in 2016. The complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents and family members advised that they were aware of the complaint's procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes. Concerns/complaints forms are available at the front entrance.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	The service has available information on the Code of Health and Disability Services Consumers' Rights. The Code of Rights (in English and Māori) is clearly displayed at the main entrance to the rest home. There is a welcome information folder that includes information about the Code of

Consumers are informed of their rights.		<p>Rights. The resident, family or legal representative has an opportunity to discuss this prior to entry and/or at admission with the manager.</p> <p>The owner/manager and registered nurse are available to discuss concerns with residents and families at any time. Residents and relatives stated they receive enough verbal and written information to be able to make informed choices on matters that affect them or their relatives.</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 service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code (link 1.2.3.3). The residents' personal belongings are used to decorate their rooms. All rooms, except one, were single occupancy during the audit with the larger two bed room currently occupied by a couple. Adequate space is available for discussions of a private nature. The healthcare assistants interviewed, reported that they knock on bedroom doors prior to entering rooms, and ensure doors are shut when cares are being given. Staff were observed knocking on doors before entering the resident rooms during the audit. All residents interviewed confirmed that their privacy is being respected.</p> <p>All resident's private information is kept in a secure area when not in use.</p> <p>Guidelines on abuse and neglect are documented in policy (link 1.2.3.3). Staff have received training on abuse and neglect prevention in 2018. The registered nurse and owner/manager stated that there is no evidence of any abuse or neglect by staff.</p> <p>There are quiet, low stimulus areas that provide privacy for residents in the dementia unit.</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>There is a Māori health plan and cultural safety policy to guide staff in the delivery of culturally safe care (link 1.2.3.3). The staff interviewed could describe how Māori interests, customs, beliefs, cultural and ethnic backgrounds are valued and fostered within the service.</p> <p>Discussions with staff confirmed that they are aware of the need to respond to cultural differences. The registered nurse and owner/manager confirmed that they would access providers in the community or through the district health board if they need to have additional cultural support or advice. Links are established with a local kaumātua who can support the service (eg, to provide blessings of rooms after a death or to provide links into local iwi).</p> <p>One resident identified as Māori on the day of the audit. Cultural and spiritual needs were assessed with a Māori health plan documented. There is a staff member who can speak Māori with the resident.</p> <p>Staff last received training on cultural awareness in 2018. Staff value and encourage active</p>

		<p>participation and input of the family/whānau in the day-to-day care of residents.</p> <p>All care staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is documented in the care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on.</p> <p>The staff emphasised a focus on using signs and body language for residents who have difficulty communicating. Staff also described using simple language and giving simple choices for residents who have dementia.</p> <p>There are no residents who do not have English as a first language. The owner/manager and staff stated that they would use interpreting services through the district health board as required. Residents are encouraged and supported to attend church services and other community groups as desired.</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>Staff described implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation (link 1.2.3.3). Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed stated that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. Job descriptions include responsibilities of the position with a job description sighted in staff files sampled.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistant's role and responsibilities.</p> <p>Residents and family interviewed confirmed that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the</p>

		complaints register since the last audit relating to any form of discrimination or exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The owner/manager described being committed to providing services of a high standard, based on the service philosophy of care and shared values. This was observed during the day with the staff demonstrating a caring attitude towards the residents.</p> <p>All residents and families interviewed spoke positively about the care provided. The general practitioner was very satisfied with the care provided and stated that any issues were escalated in a timely manner and staff give information required. There are policies and procedures which have been developed in the past by an external consultant (link 1.2.3.3).</p> <p>Staff have a sound understanding of principles of aged care and stated that they feel supported by the registered nurse and owner/manager. Monthly meetings enhance communication between the teams and provide consistency of care.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Management promote an open-door policy. Relatives were aware of the open-door policy and confirmed on interview that the staff and management were approachable and available.</p> <p>Residents/relatives can feedback on service delivery through three monthly resident and relative meetings and annual surveys. Meeting minutes evidenced that previous matters are discussed and closed out as concerns are resolved. Accident/incident forms reviewed evidenced that relatives had been informed promptly of any incidents/accidents; family interviewed confirmed that they were notified of any changes to resident's health status and were kept well informed.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they must pay for that is not covered by the agreement. An interpreter service is available if required.</p> <p>Information is provided around both the rest home and dementia units and models of care. The welcome pack included a pamphlet around dementia care. Family stated that they were well informed around the need for a secure unit for people with dementia. All residents and family interviewed stated that they had received information on entry to the service both verbally and in a written format.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned,	FA	Milton Court Rest Home provides rest home level of care and dementia level of care for up to 36 residents. There are 16 rest home beds and 20 dementia care beds. On the day of audit there were 15 rest home residents and 18 residents in the dementia unit. There was one younger

coordinated, and appropriate to the needs of consumers.		<p>person under a long-term chronic health condition contract. All other residents were under the Aged Residential agreement.</p> <p>Milton Court is privately owned and operated by one director/joint owner of the company since 2014. The director/joint owner is referred to as the owner/manager and is a registered nurse (RN) with a current practicing certificate. The other joint owner has responsibilities for the building maintenance and is the facility health and safety officer. The owner/manager is responsible for the daily operation of the business and is on site at least two days a week and as required.</p> <p>The manager is supported by a full-time registered nurse who has been at Milton Court since graduation in 2014.</p> <p>There is an annual business plan in place for 2019 which identifies the philosophy of care, mission statement, business objectives and specific aims for the service. The 2018 business goals and objectives have been reviewed.</p> <p>The manager has maintained at least eight hours annually of professional development related to managing a rest home and dementia care facility. Professional development includes attending district health board manager meetings three times a year.</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 owner/manager provides day-to-day operational management and can provide clinical oversight and hands-on support for residents when needed. They provide cover for the registered nurse when they are on leave. The registered nurse has completed at least eight hours of training relevant to the role and they provide clinical oversight of the service on a day-to-day basis. The RN provides cover for the owner/manager when they are on leave. The owner/manager stated that they would also remain in phone contact with the registered nurse while on leave.</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>	PA Low	<p>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that have been developed by an external consultant. These have not been reviewed regularly.</p> <p>The quality programme includes an annual internal audit schedule that has been implemented. Audit summaries and corrective action plans are documented where a noncompliance is identified. Issues and outcomes are reported and discussed at the staff meeting. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a</p>

		<p>timely manner.</p> <p>The monthly staff meeting includes discussion around all aspects of the quality programme including incidents, accidents, complaints, health and safety, infection control, clinical issues, staffing, survey results and discussion of improvements. The meeting serves as a forum to review progress towards goals documented in the quality plan. Discussions with the registered nurse, the owner/manager and staff, confirmed their involvement in the quality programme. Resident/relative meetings are held quarterly. The rest home residents interviewed confirmed that they value these meetings as a forum used to raise issues and to discuss any improvements or suggestions. All stated that they were kept well informed of any risks or improvements, and if issues, these were resolved in a timely manner. Meeting minutes showed evidence of resolution of issues.</p> <p>There is an annual satisfaction survey for residents and relatives. The September 2018 results showed that all residents and relatives who responded were satisfied or very satisfied with the service provided. This correlates with the responses from residents and relatives interviewed during the audit.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. The joint owner is responsible for building maintenance and is a health and safety officer who has completed level one and two of health and safety qualifications. Staff complete hazard forms for identified hazards which are reviewed by the health and safety officer. All hazard forms reviewed showed evidence of resolution of issues in a timely manner.</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>As part of the risk management and health and safety framework, there is an accident/incident policy. Eight incidents from November 2018 to day of audit were reviewed. All incident forms identified timely review by the registered nurse both of the incident and of the resident. Corrective actions to minimise resident risk were documented. Incident forms had been signed off with evidence that appropriate actions had been put in place.</p> <p>The healthcare assistants interviewed could discuss the incident reporting process. The owner/manager and registered nurse interviewed could describe situations that would require reporting to relevant authorities. There have been no reportable events to any external authorities since the previous audit.</p>

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	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development (link 1.2.3.3). Five staff files were reviewed (registered nurse, three healthcare assistants and the cook) and included all appropriate documentation. Staffing levels are stable with some staff having been employed for over six years.</p> <p>A copy of practising certificates is kept on record. The owner/manager and registered nurse have a current annual practicing certificate along with other health professionals who visit the service (general practitioner, pharmacist, podiatrist, physiotherapist).</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and skills. Reference checks are now being carried out for new staff.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff.</p> <p>There was an in-service calendar for 2019 which exceeded eight hours annually for staff who attended the 2018 training offered. There has been an emphasis on finding training to suit staff and the service is now using on-line training. Completion of this is closely monitored by the registered nurse who also sits with some staff for whom English is a second language to help with understanding of the topic. There is now 100% completion of the topics that have been offered to date.</p> <p>There are ten healthcare assistants working in the dementia care unit. Six have completed the required dementia unit standards; three are in the process of completing the required dementia unit standards and one is enrolled. One other part time staff member has completed some shifts in the dementia unit. Currently they are not enrolled in the course but are always placed on duty with a senior healthcare assistant who has completed the training.</p> <p>The owner/manager and the registered nurse are both interRAI trained. The registered nurse completes most of the interRAI assessments and the owner/manager is able to provide support when required or if the registered nurse is on leave.</p>
Standard 1.2.8: Service Provider Availability	FA	<p>The human resources policy determines 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 support. The registered nurse is on duty during the day Monday to Friday and shares</p>

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>the on-call responsibility with the owner/manager. An experienced healthcare assistant is the day supervisor who coordinates the team of healthcare assistants on duty.</p> <p>There are enough staff numbers in the rest home and the dementia care unit that meets contractual requirements. This includes two staff on each shift in the dementia unit and one on each shift in the rest home. The registered nurse provides support at all times across both the rest home and dementia unit.</p> <p>Residents and relatives stated there were always adequate staff on duty. Staff stated they feel supported by the owner/manager and the RN who respond quickly to after-hours calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and</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. All policies and procedures had been adhered to. There are no standing orders. There are no vaccines stored on site.</p>

safe practice guidelines.		<p>The facility uses a paper-based and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent HCAs administer medications. All staff have up to date medication competencies and there has been medication education this year. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication sheets. Twelve medication charts were reviewed. 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 prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a head cook who works Tuesday to Saturday and one cook who works Sundays and Mondays. There is a kitchenhand on each day from 0700-1300 and 1600-1830. The head cook has a current food safety certificate. The weekend cook is completing one. The head cook oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen and all meals are cooked on site. Meals are served in the dining rooms from bain maries. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal.</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 were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals.</p> <p>The food control plan is currently being documented.</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</p>	FA	<p>The service records the reason for declining service entry to residents should this occur 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>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) nutrition, pain and continence.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	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. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently two wounds being treated One chronic wound has had input from the GP and Hospice. There are currently no pressure injuries.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.</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 an activities coordinator who works five days a week; an activities assistant who works three mornings during the week; and a second activities assistant who works three and a half days a week including Saturdays, with most of the time spent in the dementia unit. All activities staff attend study days and the activities programme is checked by an occupational therapist annually. On the days of audit rest home residents were observed going for walks, enjoying pet therapy, watching 'The Chase' on TV and listening to a musical entertainer. In the dementia unit, residents were observed doing puzzles, going for walks, folding linen and listening to music.</p> <p>There is a weekly programme in large print on whiteboards. The programme in the dementia unit can vary from the printed programme due to residents' mood and fatigue. 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 and walks outside.</p> <p>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.</p> <p>Residents who wish to attend church go out with their families/friends, but Catholic volunteers come in to give communion weekly.</p> <p>Currently there are no van outings as the weather has been so nice that residents are walking or being pushed in wheelchairs to the beach (one block away). Van outings will start again as soon as the weather changes.</p> <p>There are regular entertainers visiting the facility. Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated. Residents are currently doing some Easter craft work. There is pet therapy weekly. There is community input from volunteers who come in weekly to have one-on-one chats. One rest home resident goes to CMA twice weekly and one resident goes to a singing group weekly.</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. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held three monthly. Residents interviewed stated that they enjoy the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Six care plans reviewed had been evaluated 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</p>

evaluated in a comprehensive and timely manner.		as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.
<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	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 mental health services for older people and the hospice. 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.
<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	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.
<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 Low	<p>The building holds a current warrant of fitness which expires 1 June 2019. There is a maintenance person who works eight hours a week over two days. They are assisted by the co-owner. Contractors are available when required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The rest home communal lounges, hallways and bedrooms are carpeted. The dementia communal lounges, hallways and bedrooms have vinyl. Corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is an enclosed outdoor area for one of the dementia units. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Staff interviewed, stated they have adequate equipment to safely deliver care for rest home and</p>

		dementia level of care residents.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	The double room has an ensuite. Fifteen rooms in the rest home have toilets and three in the dementia units. There are sufficient communal toilets and showers. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs. There are 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	There is one double room in the rest home and this is occupied by a married couple. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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	The lounges/dining areas are large. There are small nooks where residents who prefer quieter activities or visitors may sit. Activities occur in the larger areas.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	All laundry is done on site. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. 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 closed when not in use.
Standard 1.4.7: Essential, Emergency,	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. Civil defence supplies, adequate

<p>And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>food and water and a barbeque for alternative cooking are available. Emergency supplies are held in both the dementia unit and in the rest home.</p> <p>Six monthly fire evacuations are held. There is an approved fire evacuation plan dated 21 June 1996 with this reviewed by the New Zealand Fire Service on 4 December 2018. There have been no building changes. The rosters checked for February to April 2018 confirmed that there is a staff member with a first aid certificate on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells. When a call bell is activated, it can be heard and seen in any part of the building (rest home or dementia unit). This ensures that any staff can receive extra support at any time. There is a backup system of whistles which are kept in case the call bell system has a technical fault.</p> <p>Security policies and procedures are documented and implemented by staff. The dementia unit is safe and secure with outdoor access to gardens (link 1.4.2.1). The buildings are secure with 24-hour intercom access to request entry to the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is an infection control coordinator (RN) who is responsible for infection control across the facility. The coordinator liaises with and reports to the owner/manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the owner/manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical,</p>	FA	<p>The IC coordinator is a very experienced RN. They have access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</p>

and information resources to implement the infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The infection control policies include a 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 were developed by an external infection control specialist.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is training planned for 2019. Resident education occurs as part of providing daily cares and as applicable at resident meetings. The service can access an online training programme which is available for the IC coordinator and staff.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	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 including trends is discussed with the owner/manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The owner/manager and registered nurse both operate as the restraint coordinators. On the day of the audit there were no residents using restraints or enablers. Restraint education and challenging behaviours is included in the annual training programme and occurred in 2018 for all care staff. The service has been restraint free since 2012. However, it was noted that the residents in the dementia unit were restricted to

		being able to access an outdoor area when the door within the unit was locked making the unit into two units instead of one. This potentially is environmental restraint (link 1.4.2.1)
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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 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Low	There are policies in place that have been developed by an external consultant. Some have been reviewed last in 2015, however others are outdated with some having not been reviewed since 2012. Staff are familiar with the current policies and are knowledgeable around practice.	Policies have not been reviewed in response to changes in legislation or at regular intervals e.g. two to three yearly.	Ensure that policies are reviewed at regular intervals (eg, two to three yearly or as changes to legislation or practice occurs). 180 days

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The rest home buildings, plant and equipment comply with legislation.</p> <p>In the dementia unit there is a servery that directly opens on to the dining room/lounge of the dementia unit. It has a low serving shelf between the kitchen and the lounge/dining area and there is no barrier such as a shutter between the facility kitchen and the dementia unit. There is a potential risk because residents could access the kitchen at any time through the servery. The registered nurse and owner/manager stated that there have been no incidents of residents accessing the kitchen through the servery in the past 12 years. The owner/manager stated that they had considered the servery as a potential risk in 2014 and some options had been considered at that time, however these interventions had not been implemented.</p> <p>The dementia unit is at times separated by a door within the unit that is locked by a pin code (noting that if the door is locked, there is always a staff member in each 'wing'. Access to the secure outdoor garden is through one of the wings. Then the wings are separated by the locked door, the residents in the second wing cannot access a secure garden/outdoor area. Staff interviewed stated the door was often locked to make two separate units to manage residents with behaviours.</p>	<p>(i). In the dementia unit, the facility kitchen servery opens on to the dining room/lounge area. There is no barrier to close off the servery. A crock pot was also noted be sitting in arms reach through the servery opening.</p> <p>(ii) When divided into two wings, one does not have access to an enclosed outdoor area.</p>	<p>(i). Ensure that there is safety for residents at all times when in the lounge/dining area.</p> <p>(ii) Ensure that residents in the dementia unit have access to an enclosed outdoor area at all times.</p> <p>90 days</p>
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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.