Te Awa Care Limited - Te Awa Care

Introduction

This report records the results of a Partial Provisional Audit; 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:	Te Awa Care Limited
Premises audited:	Te Awa Care Ltd
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 May 2019 End date: 10 May 2019

Proposed changes to current services (if any): A partial provisional was completed to verify five serviced apartments as suitable for rest home level residents. All rooms could be used by married couples.

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

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Te Awa Lifecare Village Limited trading as Te Awa Lifecare provides rest home and hospital level care for up to 42 residents. On the day of the audit there were 21 residents living at the facility.
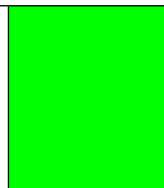
This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. The audit process included the review of documentation including policies, procedures and residents and staff files; observations; and interviews with residents, family, management, staff and one medical officer. The clinical nurse manager provides clinical oversight and input with the general manager providing strategic and operational management.

A concurrent partial provisional audit was also conducted to verify the addition of a rest home level care in five serviced apartments which are attached to the current facility. All five rooms are suitable for married couples which increases certified beds by 10. This will increase the total bed numbers from 42. This audit has verified the new serviced apartment wing as suitable to provide rest home level care.

This certification audit identified that improvements are required in relation to completion of neurological observations and meeting timeframes.

Consumer rights

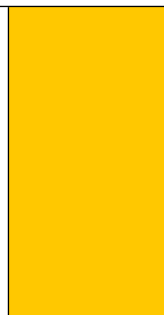|		
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural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

The service strives to provide care in a way that focuses on individualised resident care and quality of life. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is readily available to residents and families. The complaints policy is documented with processes able to be used if complaints are lodged. Residents and family interviewed, verified ongoing involvement with the community. Residents and family stated that there was a very high level of satisfaction with the service.

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 medium or high risk and/or unattained and of low risk.

Services are planned, coordinated and are appropriate to the needs of the residents. Quality and risk management processes are established with analysis and discussion of data and information through monthly meetings. The risk management programme implemented includes a risk management plan, incident and accident reporting and health and safety processes.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training is in place. The general manager is supported by a clinical nurse manager.

The organisational staffing policy aligns with contractual requirements and includes skill mixes. The clinical nurse manager is supported by registered nurses and healthcare assistants. A roster provides enough and appropriate coverage for the effective delivery of care and support. There are adequate numbers of staff on duty.

The residents' files are appropriate to the service type.

Continuum of service delivery

		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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.		

An admission package with information on the services provided at Te Awa Lifecare is available prior to or on entry to the service.

Registered nurses (RNs) assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner or nurse practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review.

The residents' activities programme provides diversional therapy activities, these are varied and include one to one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of three-monthly reviews noted.

All meals are prepared on site. There is a food control plan in place. The menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for and alternative options are made available for residents.

Safe and appropriate environment

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

Te Awa Lifecare has a current building warrant of fitness. The service has policies and procedures in place for fire, civil defence and other emergencies. Appropriate training, information and equipment for responding to emergencies are provided.

Rooms were individualised. The temperature of the facility was comfortable and able to be adjusted in resident's rooms. External areas were safe and well maintained. Residents can freely mobilise within the communal areas with safe access to the outdoors. There is wheelchair access to all areas.

Housekeeping staff maintain a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. All laundry is completed at Te Awa Lifecare. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. A van is available for transportation of residents.

The environment for the five serviced apartments with request for configuration of services to include 10 rest home beds was viewed and the environment was determined to be safe and appropriate for rest home care.

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.

Te Awa Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. On the day of the audit there were no residents with restraints and no residents using an enabler.

Infection prevention and control

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

Infection control management systems are documented to minimise the risk of infection to residents, staff and visitors. The infection control programme is implemented as per policy. The infection control officer (clinical nurse manager) uses the data and information including results of audits of the facility, hand hygiene and surveillance of infection control events to determine infection control activities, resources and education needs. Staff receive ongoing training in infection control.

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	0	2	0	0
Criteria	0	91	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (five healthcare assistants who work across all shifts; two registered nurses (RNs), one general manager (activities staff); one clinical nurse manager; chef; cleaner; maintenance) confirmed their familiarity with the Code. Interviews with eight residents, (four rest home including one requiring respite care and four hospital (including two requiring palliative cares) confirmed their knowledge of the Code. Four family members were interviewed (four hospital including one using interim care funding identified as patient centred acute community care and two requiring palliative cares), confirmed the services being provided are in line with the Code. The Code is discussed at the resident meeting.
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	Policies and procedures for informed consent and resuscitation are in place. General consents and specific consents where applicable were obtained on admission and updated as required. These were sighted in the five residents' files reviewed. Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files

informed choices and give informed consent.		for residents deemed incompetent to make decisions. Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents can participate in as much as they desire and can safely do. Resident meetings have been held once and there is a planned approach to further meetings to be held. Residents and family are encouraged to discuss any issues with the general manager, clinical nurse manager and registered nurses, all of whom have an open-door policy. Family interviewed confirmed that they do discuss any issues with managers or staff. The service encourages the community to be a part of the residents' lives in the service with visits from entertainers. Independence is encouraged with support for each resident to maintain activities they have been engaged in, in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints procedure to guide practice. The general manager has overall responsibility for managing the complaints process at the service. A record of all complaints can be maintained on VCare (electronic register) and in a hard copy manual. There have not been any complaints to date and residents and family interviewed stated that any improvements are able to be discussed with the general manager or clinical care manager. All stated that any improvements suggested are dealt with immediately as issues are raised.

		The complaints procedure is provided to resident/relatives at entry. Discussion with residents and relatives confirmed they were provided with information on the complaint process. There have not been any complaints from external authorities since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) on display in the facility and leaflets are available in the foyer. The service can provide information in different languages and/or in large print if requested. Information is given to next of kin or enduring power of attorney (EPOA) and to the resident on admission to the service. The clinical nurse manager confirmed that they discuss the information pack with the resident and the family/whānau as part of the entry process. The information pack includes a copy of the Code. The resident meetings are an opportunity for residents to discuss application of the Code and for staff to confirm access to advocacy services. Residents and relatives interviewed confirmed information has been provided around the Code and the complaints process.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met. A policy describes spiritual care. Residents access church or spiritual services in the community and all residents interviewed stated that this met their needs. A minister of one church does come into the service to provide specific rites as requested by a resident. Staff have received training around recognising abuse and neglect and staff interviewed were conversant around this. There have been no reported incidents of abuse or neglect. The general practitioner, general manager, care staff interviewed confirmed that there was no evidence of any abuse or neglect at the facility. The residents and family members stated that the philosophy of the service has meant that 'there is absolutely no evidence of abuse and neglect and quite the opposite in fact'. The service encourages residents to continue to be a part of the community and engage in activities in the community whenever possible. They also encourage family and visitors into the facility. Village and care centre residents also engage in activities together and both have access

		to facilities and activities such as the movie theatre and bowls.
Standard 1.1.4: Recognition Of Māori Values And Beliefs

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no residents who identified as Māori on the day of the audit.

Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process and review. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. 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 resident. Staff interviewed could describe how they would support a resident who identified as Māori and described asking family and the resident what cultural cares and activities they would like.

Family/whānau involvement are encouraged in assessment and care planning. Visiting is encouraged, and staff can describe the importance of family for Māori.

The service has links with iwi including Ngati Haua and Ngati Koro Ki Kahukura. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau. Values and beliefs have been discussed at the initial assessment and care planning meeting and then incorporated into the care plan. Six monthly care planning meetings are scheduled to assess if needs are being met. Family are invited to attend.

Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are implemented policies and procedures to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.

Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment or financial exploitation. Professional boundaries are reconfirmed |

		through education and training sessions, staff meetings, and the clinical nurse manager stated that performance management would address any concerns if there was discrimination noted.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that aligns with the health and disability services standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The general manager and clinical nurse manager work closely together to achieve objectives, progress key performance indicators and to improve the service. The board of directors also monitors progress overall. The managers are embedding a philosophy of person-centred care and for staff to respond to any request from a resident or family member. The satisfaction survey results and interviews with residents, relatives and the general practitioner confirmed a very high level of satisfaction with all aspects of care and service delivery provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Documentation of accidents, incidents and complaints; and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and to ensure that full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms confirmed that family were informed of any incident. Residents and family members interviewed confirmed that relatives are notified of any changes in their family member's health status. A welcome pack is provided to potential residents and family on entry to the service or when there are enquiries into the service. Residents and family interviewed stated that this was useful. There is one resident with English as a second language, however, they also speak English. There are two staff who speak their language and one has been assigned as the key worker for the resident. Staff can access interpreting services if required through a nationwide interpreting service or through the district health board.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned,	FA	Te Awa Lifecare is a new purpose-built facility on the rural outskirts of Cambridge. The facility is across one level and currently includes a total of 32 dual-purpose (hospital and rest home) beds. On the day of audit there were 21 residents (15 rest home including two respite and 6 hospital including one resident on a Patient Centred Convalescent Care Contract). The service was

coordinated, and appropriate to the needs of consumers.		opened on 1 August 2018.

The service is governed by a board of two directors who have experience in owning aged care facilities. Te Awa Lifecare has a strategic executive plan (1 August 2018 to 1 August 2019) and a business plan that cascades from the strategic plan.

There is a philosophy of care documented. Te Awa Lifecare's vision is 'Helping our people make the most of every day'.

An experienced management team is employed to manage the new service. The general manager has extensive experience in managing businesses and is supported by a clinical nurse manager (registered nurse) who has many years' experience in Hospice care particularly as a clinical nurse specialist.

The managers have maintained at least eight hours annually of professional development activities relevant to their roles.

Partial Provisional

As part of this audit, five serviced apartments as verified as suitable to provide rest home level care. The apartments are large enough for married couples and therefore potentially 10 beds (two beds in each serviced apartment) have been verified as suitable. The audit verified that the staff roster, equipment requirements, documented systems and processes are appropriate for providing rest home level care in the self-contained apartments. |
| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the general manager, the clinical nurse manager is in charge, noting that the general manager stated that they would remain in contact at all times. The clinical nurse manager is supported by a registered nurse with experience in aged care when on leave. |
| Standard 1.2.3: Quality And Risk Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement | FA | The general manager advised that they are responsible for providing oversight of the quality programme. There is a quality plan that is ratified by the Board of Directors. Quality objectives (key performance indicators) are documented and reported and discussed at staff meetings. The objectives align with the strategic executive plan with progress also reported to the Board of Directors. Objectives are reviewed as per dates documented against each.

The service's policies are reviewed annually or as changes occur, with input from the general and |

		clinical nurse managers. Staff have access to manuals.
principles.		The quality programme includes an annual internal audit schedule that is being implemented. Audit summaries and corrective action plans are documented where a non-compliance is identified. Issues and outcomes are reported through the monthly meetings. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a timely manner. All aspects of the quality and risk management programme are included in meetings which also serve as forums to review progress towards goals. Resident meetings have been initiated and there are opportunities for relatives to have input into the service through the open-door policy of the general manager. A satisfaction survey completed in January 2019 evidenced a high level of satisfaction with the service. There were no areas identified for improvement in the survey results.
		The service has a risk management and health and safety management system. There are implemented policies and plans 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	There is an accidents and incidents reporting policy. The general manager and clinical nurse manager investigate accidents and near misses and provide an analysis of trends. The clinical nurse manager conducts clinical follow-up of residents. Ten incident forms sampled from January 2019 included appropriate follow-up by the clinical nurse manager and investigation of incidents to identify areas to minimise the risk of recurrence. Monthly analysis of incidents by type has been undertaken by the service and reported to meetings. Neurological observations are not documented as per policy for any resident with a fall involving a head injury or for an unwitnessed fall. Senior management are aware of the requirement to notify relevant authorities in relation to essential notifications. There has not been any need to complete a Section 31 notification to the Ministry of Health to date.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance	FA	There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and skills. A copy of practising certificates is

with good employment practice and meet the requirements of legislation.		kept for staff and external health providers, with all current. Six staff files were reviewed (the clinical nurse manager, the general manager, one registered nurse, chef and two healthcare assistants) and all included all appropriate documentation. This included a contract relevant to the role, a job description and evidence of orientation and training. Performance appraisals are not required to be completed yet. Healthcare assistant and registered nurse staffing levels are stable. 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. New staff interviewed stated that they had an in-depth orientation programme that included reading of policies and a buddy system that was in place for at least three weeks. There was a completed in-service calendar from August 2018 to date which exceeded eight hours annually for staff who attended the training offered. One registered nurse is interRAI trained with the general manager and clinical nurse manager also trained in the management component of interRAI. There are a total of 28 staff employed at the service including 11 healthcare assistants; seven registered nurses; general manager (activities staff); clinical nurse manager; four kitchen staff and four household staff. Partial Provisional There are sufficient staff employed to cover the current serviced apartment rooms. No further training has been identified at this stage.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a policy that includes staff rationale and skill mix. A review of rosters (April 2019 to current) confirmed that there are sufficient staff rostered and staff are replaced when on leave. Staffing across the dual-purpose beds is designated to specific wings identified as RD1 (19 beds with an occupancy of 18 residents) and RD2 (13 beds with three occupants). Staffing is allocated across both RD1 and RD2, noting that this is adjusted for acuity and resident numbers). Staff work currently across both RD1 and 2. There is always at least one registered nurse on duty along with five healthcare assistants in the morning, four in the afternoon and one overnight. The roster has already been adjusted to increase by one extra healthcare assistant on morning and afternoon shifts to cater for five admissions booked to come in the following days after audit. There is an on-call process for after hours and staff are aware of how to escalate any concerns. Currently the clinical nurse manager is on call with a registered nurse able to provide backup on

		call if required. The general manager stated that they live on site and are always able to be contacted.
		Partial Provisional:
		The service is well staffed for the number and acuity of residents in the service. There is a draft roster for the increase in resident numbers in serviced apartments. The roster allows for the increase of staff due when the acuity of residents increases. The rooms are linked by a hallway to the existing rooms
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant health care assistant or registered nurse.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Prior to entry to Te Awa Lifecare potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whanau at entry. The information pack includes all relevant aspects of the service. The Te Awa Lifecare admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The facility uses the yellow envelope system for transfer documentation with a copy of details being kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.
Standard 1.3.12: Medicine Management	FA	There are policies and procedures in place for safe medicine management that meet legislative

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		requirements. Registered nurses administer medications and medication competent carers check medications when required. These staff have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored either in the residents locked drawers or in the medication room. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were four residents self-medicating on the day of audit. Self-medicating competencies were being completed 3-monthly. Ten medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication around. Partial Provisional Each resident has a locked cabinet in their room. The registered nurse will access the locked cabinet within that room to access the medication during the medication round. The exception is the controlled drugs which will be kept in the safe in the facility medication room.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on site for Te Awa Lifecare. The Food Control Plan expires on 14 September 2019. Te Awa Lifecare has a large kitchen with a receiving area and food preparation and dish washing area. A qualified chef works Monday to Friday. The sous chef works Sunday to Thursday. There are two kitchenhands employed. There are always three staff employed daily in the kitchen. Kitchen staff have completed food safety units. The menus are seasonal and rotate on a four-weekly basis. The menu has been audited and approved by a dietitian. There are snacks available throughout the day. Residents can choose to have breakfast in their room. All residents have a fridge, microwave and kitchenette available in their rooms. Cultural preferences and special diets are met including pureed diets and high protein diets. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Food is transferred from the kitchen in hot boxes and served in resident's rooms or in one of the dining rooms. Fridge and freezer temperatures are recorded daily. There is evidence that food temperatures are taken and recorded daily. All temperatures are recorded in a computer programme. All foods were date labelled and stored correctly. A cleaning schedule is maintained, this was sighted. Residents and family members interviewed were happy with the food served and range of options available. Alternatives are offered for dislikes.

		Partial Provisional.
		There is a lounge/dining table area at the end of the wing. In addition, they have dining room / lounge within each apartment. It will be the resident's choice where they would like to eat. Food is to be transferred from the kitchen in hot boxes and served in resident's rooms or in one of the dining rooms.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If entry is declined, the management staff at Te Awa Lifecare communicate directly with the referring agencies and family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	There was evidence in files reviewed that the RN completes an initial admission assessment which includes relevant risk assessment tools (link 1.3.3.3). Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. InterRAI initial assessments and assessment summaries were in place for the two long-term resident files reviewed (link 1.3.3.3). Additional assessments for management of wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed were reflective of the outcomes of the interRAI and risk assessment tools completed. Care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. There was evidence of allied health care professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian, and the wound specialist nurse. Short-term care plans to guide staff in the delivery of care for short-term needs were in use for changes in health status, these were sighted. These were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. The care plan for the resident on an end of life contract included input from the hospice. The respite resident had a short-stay care plan in place.

| Standard 1.3.6: Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed recorded communication with family.

Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.

There were six wounds being treated on the day of the audit. Four residents had wounds; one resident had three wounds; and there were no pressure injuries being treated at the time of audit. Wound assessments had been completed for all wounds. There was evidence of GP involvement for all wounds. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.

Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions. The long-term care plans and active short-term care plans are in the electronic software system, 'VCare' used for resident care. |
| Standard 1.3.7: Planned Activities

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Activities for residents occur daily on a group or one to one basis. The activities programme is designed to reflect residents' interests. The 'Care Suite calendar' displays the group activities scheduled for residents in the care suite. A personal activities assessment is completed after admission in consultation with the resident and/or family/whānau. The assessment captures a resident's interests, career, and family background. This information is then used to design the activity plan. A record is kept of individual resident's activities. The activity sections of the care plan are reviewed six monthly.

One to one and group activities are provided. The one to one activities are focused on the resident's personal interests. Community access includes van trips. Community involvement includes engagement with the Te Awa village and the wider community. Families and residents interviewed reported they enjoyed the activities programme. Popular activities include happy hour, musical entertainment, and an ANZAC tree planting was also popular.

The general manager has experience and qualifications in event planning and management and |

		has taken the role of activities coordinator. This role takes 15-20 hours per week and has been in place for approximately six months.
		A residents meeting has been held since the opening of the facility; residents met and contributed ideas for activities and decision making for the site. More meetings are planned.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed in two of the three files sampled (link 1.3.3.3). None of the resident's files sampled had been at Te Awa Lifecare for six months. Therefore, a six monthly interRAI reassessment and long-term care plan evaluation as not been completed yet. Long term care plans have been updated when there has been a change of health status and short-term care plans have been evaluated against desired goals. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Family are involved in care plan review and informed of any changes. There was evidence that the GP reviews the residents at least three-monthly or earlier if required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. A yellow transfer envelope is used when residents are transferring to hospital. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. The RNs interviewed described the referral process to other medical and non-medical services.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals were correctly labelled and stored safely throughout the facility. The hazard register identifies hazardous substances. The maintenance person described the safe management of hazardous material. There is a sluice room with personal protective equipment available. Staff have completed chemical safety training. The cleaners transfer the chemicals to a trolley, which they take with them when cleaning. A chemical spills kit is available.

Standard 1.4.2: Facility Specifications

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 12 July 2019.

Reactive and preventative maintenance occurs. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment is all less than 12 months old and has been scheduled for calibration and servicing in September 2019. The project manager for the construction site oversees maintenance at Te Awa Lifecare and liaises with the General Manager. Essential contractors are available 24-hours a day. Fire equipment is checked by an external provider.

The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.

The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.

The caregivers and RNs stated they have enough equipment to safely deliver the cares as outlined in the resident care plans.

Partial Provisional.

The five serviced apartments in which rest home with request for configuration of services to include rest home beds (is connected to the care suite section of Te Awa Life care by wide corridors and the environment was determined to be safe and appropriate for rest home care. Each serviced apartment is verified as suitable for couples which potentially could be 10 beds overall. There is adequate equipment available to provide rest home care within the apartments. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate toilets and showers in Te Awa Lifecare. All residents' bedrooms have toilets and ensuites. The toilets and showers in communal areas are accessible to residents, visitors and staff. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets contain flowing soap and paper towels. Communal toilets and bathrooms have appropriate signage and locks on the doors. Residents interviewed stated their privacy and dignity are maintained while staff attend to their personal cares and hygiene.

Partial Provisional.

The five serviced apartments have ensuites with a toilet included and in addition there is a |

		separate toilet available within the apartment. The ensuites are sufficiently spacious for disabled access. They are fitted with an emergency call bell which rings through to the nurses' station. There are adequate communal toilets available.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Bedrooms are spacious, and residents can manoeuvre mobility aids around the bed and within their personal space. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments. Partial Provisional. The bedrooms in the serviced apartments have adequate room to safely manoeuvre mobility aids and hoists and are fitted with call bells that link to the nurse's call station.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are three lounges, four dining rooms, an internal bowling green, snooker room, cinema, hair salon, art and craft room, gym and proposed cafeteria. All areas are easily accessible for residents. Furnishings and seating are appropriate for the resident group. Residents were seen moving freely within the communal areas during the days of the audit. Residents interviewed reported they can move freely around the facility and staff assist them as required. Partial Provisional. Each of the five-serviced apartment contain an open plan lounge and dining area with ample room for accessibility to safely manoeuvre mobility aids. They connect by hallways to the communal facilities. There is a communal lounge available.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services. All laundry is completed at Te Awa Lifecare on site. There are two laundries, one is dedicated to personal items and the other laundry is for towels, sheets and bedding. The cleaning staff have completed chemical safety training. The laundry has an entry and exit door. Personal protective clothing is available as required including gloves, aprons and face masks. The cleaners' trolleys are stored in a locked area when not in use. There are dedicated cleaning staff and the laundry is currently undertaken by healthcare assistants. Partial Provisional.

		Te Awa Lifecare has laundry and cleaning facilities that are designed to manage additional laundry and cleaning requirements for residents within the five serviced apartments.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate training, information, and equipment for responding to emergencies is provided at induction and is included as part of the annual training programme. Staff training in fire safety and a fire drill has been completed for new staff in the induction prior to opening. There has been a second fire drill provided to staff since the opening in August 2018 to ensure that six monthly training is provided. There are comprehensive civil defence and emergency procedures in place. There are civil defence kits and large water tanks available on site. Key staff hold a first aid certificate and a review of the rosters for April 2019 confirmed that there is always at least one staff with a first aid certificate on site. A review of staff files also confirmed that key staff have a first aid certificate. Smoke alarms, sprinkler system and exit signs are in place in the building. The fire evacuation plan was approved on the 31 August 2018. The facility has emergency lighting and torches. There is a generator, gas BBQ and additional cylinders are available for alternative cooking. There is a security policy in place with checks overnight. The service has purchased a mobility van and there is a transportation policy that links to residents outing policy and vehicle driver competency assessment. There is an automated sliding door entrance to the lobby. This is locked afterhours. Anyone is free to leave at any time from the inside during afterhours, by pushing the exit button. The call bell system is available in all areas with visual display panels. Call bells are available in all resident areas, (i.e., bedrooms, ensuite toilet/showers, communal toilets, dining rooms). The call bell system is connected to pagers. A check of response to call bells was made during the audit and confirmed that all were answered promptly. Partial Provisional. Call bells are located in serviced apartment lounges, ensuites and bedrooms. Call bell response time was checked to ensure that staff would get to the serviced apartments in a timely manner. This confirmed a response of less than two minutes to call bells rung in the serviced apartments. The apartments are part of the same building as the care centre and come under the emergency management plan.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The environment was maintained at a safe and comfortable temperature. Residents are provided with adequate natural light and safe ventilation. The residents and family interviewed confirmed the temperature of the facility is comfortable. Partial Provisional. The five serviced apartments had adequate natural light, ventilation and a comfortable room temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the reporting system documented on VCare. Infection control internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme is due for review later in 2019.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The clinical nurse manager is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and hand gel is freely available. The service has links to an IC nurse specialist through the district health board. Infection control reports are reported to staff meetings with discussion documented.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and	FA	There are policies and procedures developed by an external consultant appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.

appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control education for staff has occurred both as part of staff orientations and as part of the annual education schedule. The infection control coordinator has attended infection control training last in April 2019. Staff provide education to residents around infection control as required. Visitors would be advised of any outbreaks of infection and staff stated that they would be advised not to attend until an outbreak had been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in the service's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly through meetings and outcomes and actions are discussed. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. There are no residents using either restraint or an enabler. Enabler use is voluntary. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. The clinical nurse manager monitors any potential use of restraint or enablers.

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 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	There is a documented expectation in policy to complete neurological observations for any resident with a fall involving a head injury or for an unwitnessed fall. Of the ten incident forms reviewed, six should have had neurological observations documented as per policy for any extended period. Two of the six forms confirmed that neurological observations were taken and documented as per policy.	Four of six incident forms for a resident with a fall involving a head injury or for an unwitnessed fall did not have neurological observations taken and documented as per policy.	Ensure that neurological observations are documented as per policy for any resident with a fall involving a head injury or for an unwitnessed fall. 90 days
Criterion 1.3.3.3 Each stage of service provision	PA Low	Five resident files were sampled. This included two rest home resident files (one resident was a respite resident), and three hospital files (including one resident on a	(i) One out of five of the initial assessments were not completed within 24 hours; (ii)	(i) Ensure initial assessments are completed within 24

| (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | | Patient Centred Convalescent Care Contract and one resident who was receiving end of life care). The files reviewed identified that not all initial nursing assessments; initial care plans, interRAI assessments and long-term care plans had been completed within the required timeframe. All residents had been admitted within 6 months and therefore a 6-month care plan evaluation has not yet been required. | two out of five initial care plans were not completed within 48 hours; (iii) two out of two interRAI assessments were not completed within 21 days. (iv) two out of three long-term care plans were not completed within 21 days. | hours, (ii) ensure initial care plans are completed within 48 hours, (iii) ensure interRAI assessments are completed within 21 days, and (iv) ensure long-term care plans are completed within 21 days.

90 days |
| --- | --- | --- | --- | --- |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.